

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07109

07123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN IB 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7302 Dunmanway		d. STREET ADDRESS 7302 Dunmanway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUSTIN VICTOR ACHE		4. DATE OF DEATH Month Day Year July 1st, 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hoist Eng.		10b. KIND OF BUSINESS OR INDUSTRY Steel Erection	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Ache		14. MOTHER'S MAIDEN NAME Amanda Lynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 022-10-552	
17. INFORMANT Anna M. Ache		Address 7302 Dunmanway, Dundalk	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO 5 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 minute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12-57 19, to 7-1-57 19, that I last saw the deceased alive on 7-1- 19, 57 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. K. Wong M.D. 6801 Belair Rd., Balt 6 md. 7/3/57			
ACTUAL SIGNATURE WYMAN K. WONG		PHYSICIAN'S NAME (Type) WYMAN K. WONG	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/57	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Hellertown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Smith Bradley, Inc.		ADDRESS Dundalk 22, Md.	
24a. REC'D BY REGISTRAR 8		DATE 1957	

BUREAU V.

1957 8 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07110

Reg. Dist. No. 30

07136

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2124156 716157 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSP.				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ BALTIMORE 3V01-4 d. STREET ADDRESS 641 N. AUGUSTA AV., BALTO, 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ALBRECHT			4. DATE OF DEATH Month Day Year July 6, 1957				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-65		9. AGE (In years last birthday) 91 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stock Clerk, Hopper McGaw		10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) U. S. A.			
13. FATHER'S NAME FREDERICK ALBRECHT			14. MOTHER'S MAIDEN NAME WILMINA				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MRS. LOUISA MUND Address 641 N. AUGUSTA AV., BALTO. 29			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Generalized Arterio Sclerosis. DUE TO (b) Malnutrition DUE TO (c) Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hematoma chest left 903.7 Antero lateral Senile Psychosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. Fall on hospital ward 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 6/17/57 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work Hospital 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville at rd 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Jul. 8/57 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 22d. LOCATION (City, town, or county) (State) Balto. Md. 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave 24a. REC'D BY REGISTRAR 7/8/57 24b. REGISTRAR'S SIGNATURE R. St. Hedrich							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

07137

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTCH CLIFF NEARTOWSON</u>				c. LENGTH OF STAY IN 1b <u>XO RURAL TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENARM ROAD</u>				d. STREET ADDRESS <u>GLENARM ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARY BENONITA ALLMANN</u>				4. DATE OF DEATH Month Day Year <u>JULY 27 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 24, 1884</u>	9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER RELIGIOUS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GATES, NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JACOB GEORGE</u>				14. MOTHER'S MAIDEN NAME <u>JULIANA DOERNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>SISTER M. PETER FOURIER NOTCH CLIFF, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSON'S SYNDROME</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>52</u> , to <u>JULY</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 23rd</u> , 19 <u>57</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Charles F. O'Donnell</u> M.D. <u>7501 YORK RD. TOWSON 4 MD.</u> <u>7/22/57</u>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>							
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Villa Maria laem. Notch cliff or Towson, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zeiler</u>				ADDRESS <u>901 S. CONKLING ST. BALTO, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 29 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Notch cliff</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE [Faint text]		TIME [Faint text]	

BUREAU V. 1

JUL 30 1957

RECEIVED

07138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines Nursing Home		d. STREET ADDRESS 1725 Selma Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Sherman H. Atherton		4. DATE OF DEATH Month Day Year July 1, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1881
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
11. BIRTHPLACE (State or foreign country) Worcester, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gayland Atherton		14. MOTHER'S MAIDEN NAME Lucia Hesselton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Victoria Atherton		Address 1725 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident - Hemiparesis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 22, 1957 , to 7/1 , 19 57 , that I last saw the deceased alive on 7/1 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. H. Gleditsch M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-4-57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE JUL 5 57		24b. REGISTRAR'S SIGNATURE Out with	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

07139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN TB 3½ yrs.		d. STREET ADDRESS 1802 N. Milton Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle M Last Bafford		4. DATE OF DEATH Month 7 Day 8 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 8 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitress		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis 15 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10 , 19 53 , to 7/8 , 19 57 , that I last saw the deceased alive on 7/7 , 19 57 , and that death occurred at 6:42P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd	
PHYSICIAN'S NAME (Type) Charles F O'Donnell		DATE SIGNED 7/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57	
22c. NAME OF CEMETERY OR CREMATORY LONDON PARK NATI		22d. LOCATION (City, town, or county) (State) BALTO Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J Ruck		ADDRESS 5305 Hayford	
24a. REC'D BY REGISTRAR DATE 10 57		24b. REGISTRAR'S SIGNATURE Quilman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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JUL 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. *101*

07140

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Harford.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <i>Aberdeen 12312</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor</i>				d. STREET ADDRESS <i>34 W. Belkiss Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Frank</i> Middle <i>E.</i> Last <i>Baker</i>				4. DATE OF DEATH Month <i>July</i> Day <i>12</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12, 1877</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bricklayer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Food Cannery</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles W. Baker</i>				14. MOTHER'S MAIDEN NAME <i>Emma Michael</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Frank E. Baker</i> Address <i>Aberdeen Md. 34 W Belkiss Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diverticulitis & Colic</i> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, General</i> DUE TO (c) <i>Art. Sclerotic Heart Disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4-5 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>420.0</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 11, 1956</i> to <i>July 12, 1957</i> , that I last saw the deceased alive on <i>July 11, 1956</i> , and that death occurred at <i>7:15 p.m.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ward B. Allen</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>6 E. Eager St. Balt 2-7-12-57</i>			
PHYSICIAN'S NAME (Type) <i>WARDE B. ALLEN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Bakers Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Sarving</i>				ADDRESS <i>Aberdeen Md.</i>		24a. REC'D BY REGISTRAR DATE <i>July 15 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. L. Smith</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSP		d. STREET ADDRESS 704 S. Port Ave.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last BANKARD		4. DATE OF DEATH Month 7 Day 17 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 17 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BANKARD		14. MOTHER'S MAIDEN NAME ANNIE RICHERT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC Heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 14, 1913 , to JULY 17, 1957 , that I last saw the deceased alive on JULY 17, 1957 , and that death occurred at 3:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED Spring Grove State Hosp. 7-17-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		Catonville 22, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-19-57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR JUL 22 57	
24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include: "DEATH", "CAUSE OF DEATH", "PLACE OF DEATH", "DATE OF DEATH", "AGE", "SEX", "RACE", "BIRTH", "MARRIAGE", "EDUCATION", "OCCUPATION", "RELIGION", "MANNER OF DEATH", "PLACE OF BURIAL", "DATE OF BURIAL", "NAME OF FUNERAL HOME", "NAME OF MINISTER", "NAME OF CLERGYMAN", "NAME OF CHURCH", "NAME OF CEMETERY", "NAME OF INTERVIEWER", "NAME OF REPORTER", "NAME OF REGISTRAR", "NAME OF CLERK", "NAME OF ASSISTANT CLERK", "NAME OF CHIEF CLERK", "NAME OF DEPUTY CHIEF CLERK", "NAME OF ASSISTANT DEPUTY CHIEF CLERK", "NAME OF CHIEF OF BUREAU", "NAME OF DEPUTY CHIEF OF BUREAU", "NAME OF ASSISTANT CHIEF OF BUREAU", "NAME OF DEPUTY ASSISTANT CHIEF OF BUREAU", "NAME OF CHIEF OF DIVISION", "NAME OF DEPUTY CHIEF OF DIVISION", "NAME OF ASSISTANT CHIEF OF DIVISION", "NAME OF DEPUTY ASSISTANT CHIEF OF DIVISION", "NAME OF CHIEF OF SECTION", "NAME OF DEPUTY CHIEF OF SECTION", "NAME OF ASSISTANT CHIEF OF SECTION", "NAME OF DEPUTY ASSISTANT CHIEF OF SECTION", "NAME OF CHIEF OF OFFICE", "NAME OF DEPUTY CHIEF OF OFFICE", "NAME OF ASSISTANT CHIEF OF OFFICE", "NAME OF DEPUTY ASSISTANT CHIEF OF OFFICE", "NAME OF CHIEF OF UNIT", "NAME OF DEPUTY CHIEF OF UNIT", "NAME OF ASSISTANT CHIEF OF UNIT", "NAME OF DEPUTY ASSISTANT CHIEF OF UNIT", "NAME OF CHIEF OF BRANCH", "NAME OF DEPUTY CHIEF OF BRANCH", "NAME OF ASSISTANT CHIEF OF BRANCH", "NAME OF DEPUTY ASSISTANT CHIEF OF BRANCH", "NAME OF CHIEF OF DIVISION", "NAME OF DEPUTY CHIEF OF DIVISION", "NAME OF ASSISTANT CHIEF OF DIVISION", "NAME OF DEPUTY ASSISTANT CHIEF OF DIVISION", "NAME OF CHIEF OF SECTION", "NAME OF DEPUTY CHIEF OF SECTION", "NAME OF ASSISTANT CHIEF OF SECTION", "NAME OF DEPUTY ASSISTANT CHIEF OF SECTION", "NAME OF CHIEF OF OFFICE", "NAME OF DEPUTY CHIEF OF OFFICE", "NAME OF ASSISTANT CHIEF OF OFFICE", "NAME OF DEPUTY ASSISTANT CHIEF OF OFFICE", "NAME OF CHIEF OF UNIT", "NAME OF DEPUTY CHIEF OF UNIT", "NAME OF ASSISTANT CHIEF OF UNIT", "NAME OF DEPUTY ASSISTANT CHIEF OF UNIT", "NAME OF CHIEF OF BRANCH", "NAME OF DEPUTY CHIEF OF BRANCH", "NAME OF ASSISTANT CHIEF OF BRANCH", "NAME OF DEPUTY ASSISTANT CHIEF OF BRANCH"]

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JUL 22 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

07142

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. LENGTH OF STAY IN lb <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6008 Mannington Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George E. Barnhart</u>				4. DATE OF DEATH Month Day Year <u>July 18 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1904</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham E. Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Sue E. Frey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-8897</u>		17. INFORMANT <u>Genevieve M. Barnhart</u> Address <u>6008 Mannington Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>OBESITY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0 Sprained ankle</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr 1956</u> , to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 17, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1010 NORTH POINT RD</u>			
PHYSICIAN'S NAME (Type) <u>MORRIS A. JACOBS</u>				<u>1010 NORTH Pt. Rd.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hampden Township, Cumberland Co. Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Massahn Funeral Home 7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>JUL 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reifender</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												07117	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												31	
Item 21 Film 219 8-19-57												07143	
Reg. Dist. No.													
1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (7th)</u>				c. LENGTH OF STAY IN 1b <u>29 yrs. x 2</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (7th)</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3611 Patterson Ave Balto 7th md</u>				d. STREET ADDRESS <u>3611 Patterson Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Donald A. Bell</u>				4. DATE OF DEATH <u>7 9 1957</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 25 1927</u>		9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Verhel W. Bell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tschudy</u>									
15. WAS DECEASED EVER IN A SKIRMISHED FORCES? (Yes, No, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>No</u>				17. INFORMANT <u>Dr Arthur Bell</u> Address <u>Pikesville md</u>					
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>888.0</u> DUE TO <u>Inadvertent overdose of Alcohol & Barbiturates</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO <u></u> causes lost. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anxiety state severe (under active therapy)</u> INTERVAL BETWEEN ONSET AND DEATH <u></u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>									
20c. TIME OF INJURY Hour o. m. <u>4:00</u> Month Day, Year <u>7/9/57</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Baltimore 7 md</u> (County) <u></u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>W.E. McGroth</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7/9/57</u>					
EXAMINER'S NAME (Type) <u>W.E. McGroth</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/12/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>				22d. LOCATION (City, town, or county) <u>Pikesville, Md.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickens & Sons - Balto 17th</u>				ADDRESS <u>Balto 17th</u>				24a. REC'D BY REGISTRAR <u>Dr. Wm. E. Martin</u>				24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>	
				DATE <u>7/15/57</u>									

1709 Edmondson Ave.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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RECEIVED
JUL 16 1957
BUREAU V. S.

07147

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 W. Penn. Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Reed Britton				4. DATE OF DEATH Month Day Year 7-10-57 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26-1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Taylor				14. MOTHER'S MAIDEN NAME Sarah E. Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Richard N. Britton, 303 W. Pa. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9, 1957 to July 10, 1957 , that I last saw the deceased alive on July 9, 1957 , and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md. DATE SIGNED 7/11/57							
ACTUAL SIGNATURE George T. Gilmore M.D.				PHYSICIAN'S NAME (Type) GEORGE T. GILMORE LUTHERVILLE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks ADDRESS 622 York Rd. Towson 4, Md.				24a. REC'D BY REGISTRAR July 11, 1957		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 12 1957

07144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 Alden Road</u>				d. STREET ADDRESS <u>12900 Alden Road</u>			
3. NAME OF DECEASED (Type or print) <u>JEANNE Ethel Belle</u>				4. DATE OF DEATH <u>July - 9 - 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10 - 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PH HOME</u>		11. BIRTHPLACE (State or foreign country) <u>New York - N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Walter Burke Adde</u>				14. MOTHER'S MAIDEN NAME <u>HELEN ROONEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Louis Belle - 2900 Alden Road</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Cardio-Vascular dis.</u> <u>466X</u> DUE TO (b) <u>Thrombo-Phlebitis migrans</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Paralytic ileus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs +</u> <u>6 yrs +</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>570.1</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October</u> , 19 <u>50</u> , to <u>July 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon</u> M.D.				ADDRESS (Street, city or town, state) <u>2810 Taylor Ave. Balto. Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>				DATE SIGNED <u>7/9/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>July 19/57</u>		<u>London Crematory Balto. Md.</u>		<u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Whippert - 1300 Eutaw Pl.</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>7/10/57</u>		<u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

JUL 11 1957

RECEIVED

07145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - City of Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6400 Bellona Avenue Mercy Villa Nursing Home		d. STREET ADDRESS 2507 N. Calvert Street	
3. NAME OF DECEASED (Type or print) Mrs. Theresa O'Neill Bernard		4. DATE OF DEATH Month July Day 22 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Owen O'Neill		14. MOTHER'S MAIDEN NAME Ellen ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Roland O'Neill - 4329 Falls Road	
17. INFORMANT Mr. Roland O'Neill - 4329 Falls Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocardial Infarction July 25-1958 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis 1950 (c) Chronic Mitral Valve Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 410x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25, 1955 to July 22, 1957 , that I last saw the deceased alive on July 22, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles P. Blaudire M.D.		ADDRESS (Street, city or town, state) 3013 St. Paul St. DATE SIGNED July 23, 1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/57	22c. NAME OF CEMETERY OR CREMATORY Greenmount	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Means & Son - 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE 7/25/57	24b. REGISTRAR'S SIGNATURE Mabel Gray

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUROAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07120

07146

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Glade Ave</u>		d. STREET ADDRESS <u>14 Glade Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Barbara Braid</u>		4. DATE OF DEATH <u>July 17 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Politz</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jeannette Bichell</u>		Address <u>14 Glade Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia...aspiration</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident with Pharyngeal Paresis</u> DUE TO (c) <u>Atherosclerosis Generalized-Severe-Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>14 days</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>447X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>July 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 July</u> , 19 <u>57</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hyle</u>		ADDRESS (Street, city or town, state) <u>7527 Belair Rd Balto 6 Md</u>	
PHYSICIAN'S NAME (Type) <u>John C. Hyle MD</u>		DATE SIGNED <u>17 July 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Ave Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Duggel Bus.</u>		ADDRESS <u>7110 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JUL 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Rappaport</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07122

07148

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 29yr2mth8dys		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		d. STREET ADDRESS 1227 Poplar Grove St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Hedwig Middle Brucksch Last Brucksch		4. DATE OF DEATH Month July Day 1 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 30, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓		
13. FATHER'S NAME Roman Brucksch		14. MOTHER'S MAIDEN NAME Augusta Pirene		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 1 , 19 54 , to July 1 , 19 57 , that I last saw the deceased alive on July 1 , 19 57 , and that death occurred at 3:40p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachslor M.D. SPRING GROVE STATE HOSPITAL 7-2-57				
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-5-57		
22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 8 '57		
24b. REGISTRAR'S SIGNATURE W. H. Beach				

JUL 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149 CERTIFICATE OF DEATH

07123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 20 Ind</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prison St. 46 X - 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 209 Route 14</u>				d. STREET ADDRESS <u>Silbysville Del.</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>P.</u> Last <u>Bunting</u>				DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1880</u>	9. AGE (In years for birthday) <u>77</u>	IF UNDER 1-YEAR Months <u>16</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Williams</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Tingle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Mr Victor Emanuel</u> Address <u>Balt 20 Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>1 yr</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 8, 1957</u> , to <u>July 16, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Miceli</u>				ADDRESS (Street, city or town, state) <u>108 S. Taylor Ave</u>			
PHYSICIAN'S NAME (Type) <u>Joseph Miceli, M.D.</u>				DATE SIGNED <u>7/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>L.O.C.F.</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas W Phaley</u> ADDRESS <u>Silbysville Del</u>				24a. REG'D BY REGISTRAR <u>JUL 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

BUREAU V. S.

JUL 18 1957

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07150

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7500 MARLBORO DRIVE</u>				d. STREET ADDRESS <u>901 AISQUITH ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SR. M. FILIONA HELEN BURKE</u>				4. DATE OF DEATH Month Day Year <u>JULY 26, 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 16, 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>BOSTON, MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>EDMOND BURKE</u>				14. MOTHER'S MAIDEN NAME <u>? McREA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>SR. M. STAN. KOSKA</u> Address <u>SAME.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>57</u> , and that death occurred at <u>430 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vincent de P. Fitzpatrick Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>1120 St. Paul St.</u>			
PHYSICIAN'S NAME (Type) <u>Vincent de P. Fitzpatrick Jr.</u>				DATE SIGNED <u>7/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SISTERS' CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CHAS. ST. & HOMELAND AVES.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gailer</u>				ADDRESS <u>901 S CONKLING ST. BALTO., MD.</u>		24. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. LOCAL NUMBER OF DEATH		2. COUNTY	
3. DATE OF DEATH		4. TIME OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. DISEASE OR INJURY		8. MANNER OF DEATH	
9. SEX		10. AGE	
11. RACE		12. COLOR	
13. BIRTH DATE		14. BIRTH PLACE	
15. BIRTH DATE		16. BIRTH PLACE	
17. BIRTH DATE		18. BIRTH PLACE	
19. BIRTH DATE		20. BIRTH PLACE	
21. BIRTH DATE		22. BIRTH PLACE	
23. BIRTH DATE		24. BIRTH PLACE	
25. BIRTH DATE		26. BIRTH PLACE	
27. BIRTH DATE		28. BIRTH PLACE	
29. BIRTH DATE		30. BIRTH PLACE	
31. BIRTH DATE		32. BIRTH PLACE	
33. BIRTH DATE		34. BIRTH PLACE	
35. BIRTH DATE		36. BIRTH PLACE	
37. BIRTH DATE		38. BIRTH PLACE	
39. BIRTH DATE		40. BIRTH PLACE	
41. BIRTH DATE		42. BIRTH PLACE	
43. BIRTH DATE		44. BIRTH PLACE	
45. BIRTH DATE		46. BIRTH PLACE	
47. BIRTH DATE		48. BIRTH PLACE	
49. BIRTH DATE		50. BIRTH PLACE	
51. BIRTH DATE		52. BIRTH PLACE	
53. BIRTH DATE		54. BIRTH PLACE	
55. BIRTH DATE		56. BIRTH PLACE	
57. BIRTH DATE		58. BIRTH PLACE	
59. BIRTH DATE		60. BIRTH PLACE	
61. BIRTH DATE		62. BIRTH PLACE	
63. BIRTH DATE		64. BIRTH PLACE	
65. BIRTH DATE		66. BIRTH PLACE	
67. BIRTH DATE		68. BIRTH PLACE	
69. BIRTH DATE		70. BIRTH PLACE	
71. BIRTH DATE		72. BIRTH PLACE	
73. BIRTH DATE		74. BIRTH PLACE	
75. BIRTH DATE		76. BIRTH PLACE	
77. BIRTH DATE		78. BIRTH PLACE	
79. BIRTH DATE		80. BIRTH PLACE	
81. BIRTH DATE		82. BIRTH PLACE	
83. BIRTH DATE		84. BIRTH PLACE	
85. BIRTH DATE		86. BIRTH PLACE	
87. BIRTH DATE		88. BIRTH PLACE	
89. BIRTH DATE		90. BIRTH PLACE	
91. BIRTH DATE		92. BIRTH PLACE	
93. BIRTH DATE		94. BIRTH PLACE	
95. BIRTH DATE		96. BIRTH PLACE	
97. BIRTH DATE		98. BIRTH PLACE	
99. BIRTH DATE		100. BIRTH PLACE	

BUREAU V. 3

JUL 30 1957

RECEIVED

07151

CERTIFICATE OF DEATH

07125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1924 Wilkens Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>Carmen</u> Last <u>Calder</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Parker</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Hottle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12</u> , 19 <u>57</u> , to <u>July 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 15</u> , 19 <u>57</u> , and that death occurred at <u>2:10</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachsler</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7-15-57</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>CATONSVILLE 28, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 18 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Deane</u>			

JUL 18 1957

07152

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>MD.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>5 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Cockeysville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>1 Wight Ave.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) (Middle) (Last) <i>Emma Elizabeth Clausen</i>		(Month) (Day) (Year) <i>July 16 1957</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>July 4, 1869</i>
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
<i>88 yrs.</i>		<i>housewife</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>Balthasar Beyer</i>		<i>Anna Gertrude (unknown)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<i>No.</i>			
17. INFORMANT & ADDRESS:			
<i>Mrs. Emma Ziegler Cockeysville, Md.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <i>Arteriosclerotic cardio-vascular</i>			
ANTECEDENT CAUSE (S) DUE TO <i>disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June</i> , 1957, to <i>July</i> , 1957, that I last saw the deceased alive on <i>July</i> , 1957, and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Elizabeth B. Sherrill</i>		ADDRESS <i>Cockeysville Md.</i>	
DATE <i>7/19/57</i>		DATE <i>7/16/57</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		NAME OF CEMETERY, OR CREMATORY <i>Meadowridge Mem. Pk. Anne Arundel, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7/17/57</i>		24. FUNERAL DIRECTOR <i>Wm. Cook-Towson Inc. Towson #4</i>	

RECEIVED

JUL 19 1957

BUREAU V. S.

07153

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN TB <u>11 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek, Maryland 16 X 22</u> d. STREET ADDRESS <u>R.D. #1, Box 232</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Edna</u> Last <u>Clements</u>		4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/19/56</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Gerald Clements</u>	
14. MOTHER'S MAIDEN NAME <u>Adelta Agnes Lint</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Parents and Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure due to heart malformation (Tetralogy of Fallot)</u> DUE TO (b) <u>754.0</u> DUE TO (c) <u>Mongoloid idiocy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/15/56</u> , 19 <u>56</u> , to <u>7/24/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/24/57</u> , 19 <u>57</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u> DATE SIGNED <u>7/25/57</u>			
ACTUAL SIGNATURE <u>Harry G. Butler</u>		M.D. <u>Owings Mills, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler</u>		<u>Rosewood State Training School</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-27-57</u>	<u>St. Mary's Cemetery</u>	<u>Piscataway, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		ADDRESS <u>1400 Chopin St. NW</u>	24. REC'D BY REGISTRAR <u>Wash. D.C.</u>
24b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>		DATE <u>JUL 29 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

September 1999

BUREAU V. S.

JUL 29 1957

RECEIVED

07154

CERTIFICATE OF DEATH

07128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First Middle Last <u>Cohen</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army & Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rubin</u>		14. MOTHER'S MAIDEN NAME <u>Rachael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nathan M Cowan - same</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>10 yrs. (?)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>57</u> , to <u>7-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-25</u> , 19 <u>57</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave. 7-25-57</u>			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		M.D. <u>6209 Frederick Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Catonsville-25, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-26-57</u>	<u>Hebrew Young Men</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		24a. REC'D BY REGISTRAR DATE <u>29</u>	
ADDRESS <u>2100 Guitow Place</u>		24b. REGISTRAR'S SIGNATURE <u>G. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

72154

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF DEATH [Faint text]</p>	
<p>7. TIME OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	
<p>15. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>16. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>17. SIGNATURE OF FUNERAL HOME [Faint text]</p>		<p>18. SIGNATURE OF CHURCH [Faint text]</p>	
<p>19. SIGNATURE OF CEMETERY [Faint text]</p>		<p>20. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. S.

JUL 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

Reg. Dist. No. 32

07155

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston		c. LENGTH OF STAY IN 1b ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eccleston x2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Park Heights Ave.				d. STREET ADDRESS Park Heights Ave.			
3. NAME OF DECEASED (Type or print) Rev. Robert Henry Coleman First Middle Last				4. DATE OF DEATH July 1 1957 Month Day Year			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1920		9. AGE (in years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Protestant Episcopal Clergy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Caldwell Coleman				14. MOTHER'S MAIDEN NAME Elizabeth C. Brooke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Hon. Wm. C. Coleman, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death by strangulation due to hanging-suicide DUE TO 974x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH 6-7 hrs. (est.)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient hung self on shower bar with his belt.					
20c. TIME OF INJURY Month, Day, Year 8-9 a.m. est. 7/1/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Eccleston, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-2-57	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Thomas		22d. LOCATION (City, town, or county) (State) Garrison Forest, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co., 4905 York Rd.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7/3/57	
				24b. REGISTRAR'S SIGNATURE Dorothy Russell			

BUREAU V. 1

JUL 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07130 33

07156

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>12 x 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>Box 249, R.F.D. 1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Beatrice</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/57</u>		9. AGE (In years lost birthday) yrs. <u>22</u>	IF UNDER 1 YEAR Months <u>22</u>	IF UNDER 24 HRS. Hours <u>22</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel Boston Collins</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Mary Ann Respass</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inspiratory Pneumonia</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydrocephalus, Internal, Cong.</u> DUE TO (c) <u>Birth</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/29/57</u> , 19 <u>57</u> , to <u>7/30/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/30/57</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE: <u>Harry B. Butler</u> M.D.				ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u>		DATE SIGNED <u>7/31/57</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Bailey</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried August 1, 1957</u>		22b. DATE THEREOF <u>August 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Harford Co, Md</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 31, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary King</u>			

RECEIVED

07157
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG217 7-15-57 et
CERTIFICATE OF DEATH

07131
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>4 Months</u>		d. STREET ADDRESS <u>7107 Windsor Mill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Presbyterian Home of Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy E. Conrad</u>		4. DATE OF DEATH <u>July 2 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>Virginia</u>	
13. FATHER'S NAME <u>August Miltz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Presbyterian Home</u>	
17. INFORMANT <u>Towson, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Vascular Disease - advanced senile changes</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis (and aging)</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>290.0 Pernicious Anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4 1957</u> , to <u>July 2 1957</u> , that I last saw the deceased alive on <u>June 29 1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rollin C. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Towson 4 Md</u>	
PHYSICIAN'S NAME (Type) <u>Rollin C. Hudson M.D.</u>		DATE SIGNED <u>7/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc.</u>		ADDRESS <u>1900 Eutaw Place</u>	
24a. REC'D BY REGISTRAR <u>JUL 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07158

CERTIFICATE OF DEATH

07132

32

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wicomico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. LENGTH OF STAY IN 1b 61 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22122	
3. NAME OF DECEASED (Type or print) First Middle Last Severn Warner Crockett		4. DATE OF DEATH Month Day Year 7 6 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/2/94
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min. 6 19 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Waterman	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry S. Crockett		14. MOTHER'S MAIDEN NAME Sadie Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Maggie N. Crockett (Wife) Sal. Md. Hospital Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 11 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/6 , 19 57 , to 7/6/57 , 19 57 , that I last saw the deceased alive on 7/6 , 19 57 , and that death occurred at 6:54 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED July 6, 1957			
ACTUAL SIGNATURE William Newcomer M.D.		PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE JUL 10 1957	
24b. REGISTRAR'S SIGNATURE Dorothy Newell			

CERTIFICATE OF DEATH

67102

NAME OF DECEASED		DATE OF DEATH	
WILLIAM B. HARRIS		JULY 10 1957	
AGE		SEX	
67		M	
RACE		OCCUPATION	
W		RETIRED	
MARRIAGE		PLACE OF BIRTH	
M		BALTIMORE, MD	
EDUCATION		CAUSE OF DEATH	
H		HEART DISEASE	
RELIGION		MANNER OF DEATH	
C		N	
PLACE OF DEATH		DATE OF BURIAL	
BALTIMORE, MD		JULY 10 1957	
NAME OF FUNERAL HOME		NAME OF MINISTER	
WILLIAM B. HARRIS		WILLIAM B. HARRIS	
ADDRESS		CITY	
BALTIMORE, MD		BALTIMORE, MD	
STATE		COUNTY	
MD		BALTIMORE	

RECEIVED
JUL 10 1957
BUREAU V. 21

07159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Box 90, Dares Beach, Md. b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS Box 90 Dares Beach, Md.	
3. NAME OF DECEASED (Type or print) First Jesse Middle Mae Last Dement		4. DATE OF DEATH Month July Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-78
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel B.		14. MOTHER'S MAIDEN NAME Katherine Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Bernard Dement		Address Box 90 Dares Beach, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 443X DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **June 21**, 19**57**, to **July 13**, 19**57**, that I last saw the deceased alive on **July 13**, 19**57**, and that death occurred at **5:45 P** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **Bruno Radauskas** M.D. ADDRESS (Street, city or town, state) **Spring Grove St. Hosp. Catonsville, Md** DATE SIGNED **7/13/57**

PHYSICIAN'S NAME (Type) **Bruno Radauskas, M.D.**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-16-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert Mattingly		24. REC'D BY REGISTRAR Wade	24b. REGISTRAR'S SIGNATURE Wade

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BURIAL [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF CORONER [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. 2

JUL 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07134

07124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6807 5th.Ave.		d. STREET ADDRESS 6807 5th.Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Felix Middle Dudzinski Last Dudzinski		4. DATE OF DEATH Month July Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct.16,1889
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Dudzinski		14. MOTHER'S MAIDEN NAME Josephine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 180-01-4862	
17. INFORMANT Bertha Dudzinski		Address 6807 5th.Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerosis - especially coronary DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hr 4 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/5, 1957 to 7/12, 1957 , that I last saw the deceased alive on July 12, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R Maurice Feldman M.D.		ADDRESS (Street, city or town, state) Re Lubro, Charles St. Balto DATE SIGNED 7/13/57	
PHYSICIAN'S NAME (Type) / Maurice Feldman Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/15/57	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Balto.Co.Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski		ADDRESS 2007 Eastern Ave	
24a. REC'D BY REGISTRAR 151957		24b. REGISTRAR'S SIGNATURE M. Kelly	

BUREAU A. S.

708

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G217 7-11-57 et
07160
CERTIFICATE OF DEATH

07135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 21, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hosp.		d. STREET ADDRESS 5913 - 23rd Place, S. E.	
3. NAME OF DECEASED (Type or print) First JOHN Middle THEODORE Last DUEVER, JR		4. DATE OF DEATH Month 7 Day 6 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1885
9. AGE (In years last birthday) yrs. 71 7/2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Duever		14. MOTHER'S MAIDEN NAME Mary Reiners	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John Vasconcellos		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Chronic brain syndrome due to cerebral arteriosclerosis - depression		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-5 , 19 57 , to 7-6 , 19 57 , that I last saw the deceased alive on 7-5 , 19 57 , and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED ACTUAL SIGNATURE John Vasconcellos M.D. Baltimore, Maryland PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-57	
22c. NAME OF CEMETERY OR CREMATORY Catharist on Mt.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE L. W. Lee + Son's Co.		24a. REC'D BY REGISTRAR 300 4th St. N.W. Wash. D.C.	
24b. REGISTRAR'S SIGNATURE W. H. Beach		DATE JUL 8 '57	

BUREAU V. S.

1957 8 701

RECEIVED

07136

07161

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland		b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 18 Hrs. 25 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 32B Westway North		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN		First JOHN		Middle E.		Last DUKES	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH July 8 1957	
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Air Craft Co.		11. BIRTHPLACE (State or foreign country) Hoopers Island, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Franklin Dukes		14. MOTHER'S MAIDEN NAME Mary Phillips		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-05-8400	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		Address Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION WITH MYOCARDIAL FOCAL NECROSIS 420.1 MYO AND OLD INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7 1957 to July 8 1957 and that death occurred at 12:40 P.M. from the causes and on the date stated above.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto 14, Md.		24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Dr. Damaski Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		CORONER		BURIAL PLACE	
APRIL 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		DR. JAMES H. HAYES		DR. JAMES H. HAYES		MEMPHIS, TENN.	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH		FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH		MOTHER'S DEATH	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 2

JUL 15 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07162

CERTIFICATE OF DEATH

07137

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>				d. STREET ADDRESS <u>119 S. Tremont Road</u>			
3. NAME OF DECEASED (Type or print) <u>ESTELLA EMMA-EDELER</u>				4. DATE OF DEATH <u>July 31 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>John W. Miles</u>				14. MOTHER'S MAIDEN NAME <u>Emma Topp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Ruth E. Groves</u>				Address <u>119 S. Tremont Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident (Probably hemorrhage)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardio vascular</u> DUE TO <u>disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 7, 1957</u> to <u>July 31, 1957</u> , that I last saw the deceased alive on <u>July 31, 1957</u> , and that death occurred at <u>10:30A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Knipp</u> M.D.				ADDRESS (Street, city or town, state) <u>4116 Edmondson Avenue</u> DATE SIGNED <u>8/1/57</u>			
PHYSICIAN'S NAME (Type) <u>George A. Knipp, M. D.</u>				Baltimore 29, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 3-1957</u>		<u>Louclon Park</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Guefel</u>				ADDRESS <u>5311 Edmondson Ave</u>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE <u>AUG 2 57</u>			

AUG 2 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4-4

07163

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN IB 168 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2915 S. Denham Circle			
3. NAME OF DECEASED (Type or print) First Middle Last EARLE N. EDWARDS				4. DATE OF DEATH Month Day Year July 22 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1920	
9. AGE (In years last birthday) 36		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Brick Yard		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Earle B. Edwards				14. MOTHER'S MAIDEN NAME Gladys G. Gross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 214-14-0798		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181X PYELONEPHRITIS WITH PYONEPHROSIS, BILATERAL DUE TO CARCINOMA OF BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 600.0 (b) METASTATIC LESION TO PELVIC FLOOR, PELVIC BONE AND PROSTATE (c) CARCINOMA OF BLADDER INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS 2 1/2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation, 10/15/56, Bilateral Ureterosigmoidostomy							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from February 4, 1957 , to July 22, 1957 , and that death occurred at 5:22 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 7/23/57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VA HOSPITAL, FT. HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles B. Law Mortuary, 802 Madison Ave., Balto. 1, Md.				24a. REC'D BY REGISTRAR 7/25/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 29 1957

RECEIVED

07164

CERTIFICATE OF DEATH

07139

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yr5mthlldys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 626 N. Fulton Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Mary Last Ennis				4. DATE OF DEATH Month July Day 25 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1881	
9. AGE (In years last birthday) 75 7/8		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Remous Ennie				14. MOTHER'S MAIDEN NAME Anne Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11, 1954 , to July 25, 19 57 , that I last saw the deceased alive on July 25, 19 57 , and that death occurred at 9:55a M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 7-25-57							
ACTUAL SIGNATURE Stella Wachsler				M.D. SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-1-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Old St Pauls. O'Donnell St. Balto. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook / uc. 1217 St. Paul St.				24a. REC'D BY REGISTRAR AUG 2 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

UG 2 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07165

Item 2 Film 6219 8-16-57 et

CERTIFICATE OF DEATH

Item 2 Film 6219 8-19-57 et

07140

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b ?		10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVALESCENT HOME		e. STREET ADDRESS (6003 Hunt Club Lane)	
3. NAME OF DECEASED (Type or print) LAURA B FARSON		4. DATE OF DEATH July 26 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10b. KIND OF BUSINESS OR INDUSTRY Retired (Hutzler Balto., Md)	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August E Bruckheiser		14. MOTHER'S MAIDEN NAME Catherine Shallenberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-14-4669A	
17. INFORMANT Amos Eugene Kernan		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 CONGESTIVE HEART FAILURE DUE TO ARTERIOSCLEROTIC C-V DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 434.1 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. 1954 to JULY 26, 1957 , that I last saw the deceased alive on JULY 10, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1532 HAYWOOD ROAD BALTIMORE, MD DATE SIGNED			
ACTUAL SIGNATURE Arthur K. Krefin		M.D. 1532 HAYWOOD ROAD BALTIMORE, MD	
PHYSICIAN'S NAME (Type) ARTHUR K. KREFIN		MD. BALTIMORE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-29-57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) BALTO MD
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Krefin		ADDRESS Amos 4905 York Rd	
24a. REC'D BY REGISTRAR DATE 7/29/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07166
CERTIFICATE OF DEATH

07141
38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x 2 Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2806 Garnet Road</i>		d. STREET ADDRESS <i>1 2806 Garnet Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Gertrude E. Callender Fischer</i>		4. DATE OF DEATH Month Day Year <i>July 3rd 1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 14, 1909</i>
9. AGE (In years last birthday) <i>47</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Martin Evans</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Nickol</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Herman P. Fischer, Jr.</i>		Address <i>2806 Garnet</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>none</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-15-1957</i> , to <i>7-2-1957</i> , that I last saw the deceased alive on <i>7-2-57</i> 19, and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. S. Elliott Harris</i>		ADDRESS (Street, city or town, state) <i>8100 Harford Road, #14</i> DATE SIGNED <i>7/3/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. S. Elliott Harris</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/6/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>JUL 8 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. C. M. Mason</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9-17-75 5-5-75

5-5-75

BUREAU V. 3

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. YACHT CLUB</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3 VOI-4</u> d. STREET ADDRESS <u>2030 ST. PAUL ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND EDGAR FISHER</u>				4. DATE OF DEATH Month Day Year <u>JULY 3 1957</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-18-08</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>UNKNOWN.</u>						14. MOTHER'S MAIDEN NAME <u>MINNIE A. FISHER</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>2ND W. W.</u>				17. INFORMANT Address <u>MYRTLE I. DEEDS-2540 GREENMOUNT AVE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>FEW MINUTES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FELL INTO WATER WHILE TRYING TO FREE A GROUNDLED BOAT</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>902.4</u>											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>W. E. BAERMANN</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED			
EXAMINER'S NAME (Type) <u>W. E. BAERMANN, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u>				22d. LOCATION (City, town, or county) (State) <u>FREDERICK RD. MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>						ADDRESS <u>-3818 Roland Ave</u>		24a. REC'D BY REGISTRAR <u>JUL 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Harley</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU

107 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07168

Item 12 Film G218 7/26/57 cap

07143

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN lb 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holiday Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 v o 1 - 4 ✓	
3. NAME OF DECEASED (Type or print) First Herman Middle Fishkin Last Fishkin		4. DATE OF DEATH Month July Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Poland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Fishkin		14. MOTHER'S MAIDEN NAME Mitze	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. Benj. Chamish, 4403 Kennison Ave., Balto.	
17. INFORMANT Benj. Chamish, 4403 Kennison Ave., Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic C-V Disease DUE TO (c) 6 mos. 6 mos.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7-19-57			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-57	
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE 22 1957	
		24b. REGISTRAR'S SIGNATURE Anthony Powell	

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2

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED J. H. HENRY		AGE 45		SEX Male		RACE White		DATE OF DEATH July 22, 1957	
PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21201	
OCCUPATION None		EDUCATION High School		MARRIAGE Married		SINGLE		DIVORCED	
MARITAL STATUS Married		SPOUSE'S NAME J. H. HENRY		SPOUSE'S ADDRESS 1234 Main St. Baltimore, Md.		SPOUSE'S PHONE None		SPOUSE'S OCCUPATION None	
DECEASED'S ADDRESS 1234 Main St. Baltimore, Md.		DECEASED'S PHONE None		DECEASED'S OCCUPATION None		DECEASED'S EDUCATION High School		DECEASED'S MARRIAGE Married	
DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S AGE 45		DECEASED'S NAME J. H. HENRY		DECEASED'S PLACE OF DEATH Home	
DECEASED'S DATE OF DEATH July 22, 1957		DECEASED'S TIME OF DEATH None		DECEASED'S CAUSE OF DEATH None		DECEASED'S MANNER OF DEATH None		DECEASED'S MEDICAL HISTORY None	
DECEASED'S MEDICAL HISTORY None		DECEASED'S MANNER OF DEATH None		DECEASED'S CAUSE OF DEATH None		DECEASED'S TIME OF DEATH None		DECEASED'S DATE OF DEATH July 22, 1957	
DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S AGE 45		DECEASED'S NAME J. H. HENRY		DECEASED'S PLACE OF DEATH Home	
DECEASED'S DATE OF DEATH July 22, 1957		DECEASED'S TIME OF DEATH None		DECEASED'S CAUSE OF DEATH None		DECEASED'S MANNER OF DEATH None		DECEASED'S MEDICAL HISTORY None	

BUREAU V. 3

JUL 22 1957

RECEIVED

07169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> b. COUNTY <u>Absecon</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlantic City</u> <u>67X-3</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Amacost Home - Regester Ave.</u>				d. STREET ADDRESS <u>Lennox Apts.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER</u> <u>FOX</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>5,</u> <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Koopman</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. Robert Fox - 2020 Hanover St.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (Bronchial)</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1956</u> to <u>July 1957</u> , that I last saw the deceased alive on <u>July 4, 1957</u> , and that death occurred at <u>7:42</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.				ADDRESS (Street, city or town, state) <u>2501 York Rd</u>			
DATE SIGNED <u>2/1/57</u>							
PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>				Townson #4 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto.</u>				24a. REC'D BY REGISTRAR <u>AUG 8 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Mabel Long</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

1957 8 796

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G217 7-16-57 et

07145

07170

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 Fuller Avenue</u>				d. STREET ADDRESS <u>1 20 Fuller Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. John H. Funk</u>				4. DATE OF DEATH Month Day Year <u>July 6th 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 9, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Post Office</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>	
13. FATHER'S NAME <u>William G. Funk</u>				14. MOTHER'S MAIDEN NAME <u>Sarah C. Hudgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Anna J. Funk, 20 Fuller Ave. #6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>7-8 mo 2</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/9</u> , 19 <u>51</u> , to <u>7/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/2</u> , 19 <u>57</u> , and that death occurred at <u>5 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Garis</u> M.D.				ADDRESS (Street, city or town, state) <u>1103 St. Paul Street</u>			
DATE SIGNED <u>7/8/57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Robert W. Garis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Hargford Road #14</u>		24a. REC'D BY REGISTRAR <u>DATE 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Ruffenberger</u>			

BUREAU V. S.

10 1957

RECEIVED

07171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY 3Y01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. (formerly of Catonsville)	
c. LENGTH OF STAY IN 1b 45yr8mth7dys		d. STREET ADDRESS 1809 Park Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle L Last FURNESS		4. DATE OF DEATH Month JULY Day 18 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-78
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Alexander W. Furness		14. MOTHER'S MAIDEN NAME Miria H. -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 158X Retroperitoneal malignant tumor (Hodgkin's Disease?) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 158X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 12 , 19 57 , to July 18 , 19 57 , that I last saw the deceased alive on July 18 , 19 57 , and that death occurred at 3:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		DATE SIGNED 7-18-57	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		ADDRESS (Street, city or town, state) Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/57	22c. NAME OF CEMETERY OR CREMATORY All Saints Cem.	22d. LOCATION (City, town, or county) (State) Somerset Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Schubert & Sons, Balt.		24. REC'D BY REGISTRAR JUL 19 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1892		BALTIMORE		MD		MD		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
JUL 22 1957		10:30 AM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS	
RETIRED		HIGH SCHOOL		MARRIED		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		PARENTS		SIBLINGS		CHILDREN		GRANDCHILDREN		OTHER RELATIVES		FAMILY HISTORY		FAMILY HISTORY	
FATHER		MOTHER		BROTHERS		SISTERS		SONS		DAUGHTERS		GRANDFATHER		GRANDMOTHER	
JAMES H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		ELIZABETH H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH	
JUL 22 1957		10:30 AM		HOME		BALTIMORE		MD		USA		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS	
RETIRED		HIGH SCHOOL		MARRIED		NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		PARENTS		SIBLINGS		CHILDREN		GRANDCHILDREN		OTHER RELATIVES		FAMILY HISTORY		FAMILY HISTORY	
FATHER		MOTHER		BROTHERS		SISTERS		SONS		DAUGHTERS		GRANDFATHER		GRANDMOTHER	
JAMES H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		ELIZABETH H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS		JAMES H. HARRIS		MARY H. HARRIS	

RECEIVED
JUL 22 1957
BUREAU V. 8

07133

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5172 Viaduct Ave.				d. STREET ADDRESS 5172 Viaduct Ave.			
3. NAME OF DECEASED (Type or print) First MARTHA Middle LILLIAN Last GARLAND				4. DATE OF DEATH Month July Day 14 , Year 19 57			
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John L. Knode				14. MOTHER'S MAIDEN NAME Virginia C. Spielman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-05-3824		17. INFORMANT Mrs. Daisy Moszner-5172 Viaduce Ave., Relay, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 11, 1957 , to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 40927 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. N. Lederer				ADDRESS (Street, city or town, state) 1305 Francis Ave. Baltimore, Md.			
PHYSICIAN'S NAME (Type) J. N. Lederer				DATE SIGNED 7/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Com.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE JUL 18 1957		24b. REGISTRAR'S SIGNATURE Geo M. Kueffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JUL 18 1957

RECEIVED

07172

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore City		c. LENGTH OF STAY IN 1b 6 weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson, Maryland		d. STREET ADDRESS 119 Greenbrier Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodbrook Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Augusta Last German		4. DATE OF DEATH Month July Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 3 Days — Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY City of Baltimore	
11. BIRTHPLACE (State or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Jackson German		14. MOTHER'S MAIDEN NAME Ann Rebecca Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Robert H. Wheeler		Address Woodbrook Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma-wide-spread DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of fundus uteri DUE TO (c) Arteriosclerotic cardio-vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 43			
INTERVAL BETWEEN ONSET AND DEATH More than six months.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 19 57, to July 20, 19 57, that I last saw the deceased alive on July 20, 19 57, and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2919 St. Paul St. Balto. 18, Md. DATE SIGNED July 23 1957			
ACTUAL SIGNATURE Charlotte McCarthy M.D.			
PHYSICIAN'S NAME (Type) Dr. Charlotte McCarthy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/57	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Towson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Mass		24a. REC'D BY REGISTRAR DATE JUL 23 1957	
ADDRESS 805 N. Calvert St.		24b. REGISTRAR'S SIGNATURE Notel Guy	

RECEIVED

JUL 24 1957

BUREAU V. S.

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS	
STATE OF NEW YORK	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. DATE OF DEATH	
7. PLACE OF DEATH	
8. CAUSE OF DEATH	
9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES	
12. SIGNATURE OF DECEASED'S NEAREST RELATIVE	
13. SIGNATURE OF DECEASED'S PHYSICIAN	
14. SIGNATURE OF DECEASED'S MINISTER OF RELIGION	
15. SIGNATURE OF DECEASED'S CHURCH	
16. SIGNATURE OF DECEASED'S FUNERAL HOME	
17. SIGNATURE OF DECEASED'S BURIAL PLACE	
18. SIGNATURE OF DECEASED'S CEMETERY	
19. SIGNATURE OF DECEASED'S INTERMENT	
20. SIGNATURE OF DECEASED'S CREMATION	
21. SIGNATURE OF DECEASED'S OTHER	
22. SIGNATURE OF DECEASED'S OTHER	
23. SIGNATURE OF DECEASED'S OTHER	
24. SIGNATURE OF DECEASED'S OTHER	
25. SIGNATURE OF DECEASED'S OTHER	
26. SIGNATURE OF DECEASED'S OTHER	
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28. SIGNATURE OF DECEASED'S OTHER	
29. SIGNATURE OF DECEASED'S OTHER	
30. SIGNATURE OF DECEASED'S OTHER	

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Balt			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 24 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last GILLOTT				4. DATE OF DEATH Month JULY Day 22 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-14-86	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER				10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM H. GILLOTT				14. MOTHER'S MAIDEN NAME Elizabeth Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 1-18-05 to 8-19-32				16. SOCIAL SECURITY NO. 219-14-0607			
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 491x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART I. CHR. BRAIN SYNDROME ASSOCIATED WITH ARTERIOSCLEROSIS; PUL. EMPHYSEMA, UNK. Duration: unknown Duration: unknown INTERVAL BETWEEN ONSET AND DEATH 3 DAYS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 450.0				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 28 , 19 57 , to July 22 , 19 57 , and that death occurred at 8:22 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 7-22-57 ACTUAL SIGNATURE Armen Bogosian M.D. VAH, FORT HOWARD, Maryland 7-22-57 PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN M.D. VAH, FORT HOWARD, Maryland 7-22-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-25-57		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) PIKEVILLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE SEITZ FUNERAL HOME, 5209 YORK RD. BALTIMORE 12, MD.				24a. REC'D BY REGISTRAR 7/23/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STOKES, HALL

$$S_2 = 2.0 \times 10^{-3} \text{ mol/L}$$
[illegible]

Two-story, masonry

BUREAU V. 5

JUL 24 1957 -

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07125

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Dundalk 22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1721 Pinewood Drive				d. STREET ADDRESS 1721 Pinewood Drive			
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT WESLEY GOODWIN, SR.				4. DATE OF DEATH Month Day Year July 31 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4,	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Grain		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Edward Herbert Goodwin				14. MOTHER'S MAIDEN NAME Sara Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-8840		17. INFORMANT Address Alice G. Howard 1721 Pinewood Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Brooks Bradley				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR Aug 5 1957	
				24b. REGISTRAR'S SIGNATURE M. M. Kelly			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07151

07174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>4310 5th Paul St</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>B</u> Last <u>GRAHAM</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisburg Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Belker</u> (talker)		14. MOTHER'S MAIDEN NAME <u>Clara Aker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Walter Graham</u>		Address <u>3702 Greenway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branch pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7-14 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Adenoma Thyroid</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-25</u> , 19 <u>56</u> to <u>present</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>7/26/57</u> , 19 <u>—</u> , and that death occurred at <u>4</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Emmet C Brown</u>		M.D. <u>1101 N Calvert St-2</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 2 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins & Sons Co</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 2 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07152

07175

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 50 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON 05x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 526 GAY STREET			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C Last GREENAGE, JR.				4. DATE OF DEATH Month JULY Day 6 Year 1957			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 25, 1922	
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER				10b. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) DENTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM C. GREENAGE, SR.				14. MOTHER'S MAIDEN NAME CORNELIA WHEELER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11				16. SOCIAL SECURITY NO. 213-18-5751		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA LEFT MAXILLARY SINUS WITH 160x GENERALIZED BONE METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ INTERVAL BETWEEN ONSET AND DEATH 2 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from May 16 , 19 57 , to July 6 , 19 57 , that he was the deceased's physician, and that death occurred at 1:00 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 7-6-57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, Fort Howard, Maryland 7-6-57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH, FORT HOWARD, MARYLAND 7-6-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY SPRING GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) DENTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R. LAW MORTUARY, 802-04 MADISON AVE.				24a. REC'D BY REGISTRAR DATE July 9-57		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NAME OF DECEASED WILLIAM J. BROWN		DATE OF BIRTH 1900	
SEX MALE		RACE WHITE	
MARRIAGE 1925		OCCUPATION LABORER	
PLACE OF BIRTH NEW YORK		PLACE OF DEATH BALTIMORE	
DATE OF DEATH JULY 11 1957		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF REGISTRAR JOHN D. JONES	
SIGNATURE OF NEXT OF KIN MRS. J. BROWN		SIGNATURE OF WITNESS JOHN D. JONES	

RECEIVED
JUL 11 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Montrose Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle GRILL Last GRILL		4. DATE OF DEATH Month July Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1869
9. AGE (In years lost birthday) yrs. 87		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Keiser		14. MOTHER'S MAIDEN NAME Louisa Keebler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruth M. Disney - Dogwood Rd., Woodlawn		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Myocardial Decomposition 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) 12ms. 1530(?)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1957 , to July 18, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Catonsville, Md. DATE SIGNED 7-20-57			
ACTUAL SIGNATURE William K. Gallagher M.D.		PHYSICIAN'S NAME (Type) William K. Gallagher, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/1957	
22c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR JUL 23 '57	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DATE OF BIRTH _____		PLACE OF BIRTH _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
DISEASE OR INJURY _____		MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF REGISTRAR _____	
CITY _____		COUNTY _____	
STATE _____		YEAR _____	

BUREAU V. S.

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07154 45

Reg. Dist. No.

07177

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE-RIVER</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 MIDDLE - RIVER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Box 524 BAYDRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>GUNSAIUS</u>				4. DATE OF DEATH Month <u>7</u> Day <u>-25</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1911</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GLENN-MARTIN</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES GUNSAIUS</u>				14. MOTHER'S MAIDEN NAME <u>PEARL RINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>LORNA GUNSAIUS</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly - Essex, Md</u>				24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurlay</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

107 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07155

Reg. Dist. No.

07178

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Glenn</u> Middle <u>Edward</u> Last <u>Haines</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>49</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Haines</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Willman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Records Spring Grove State Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration Brain temporal lobe</u> <u>353.3</u> DUE TO <u>left (contre coup)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epileptic Seizure</u> (c) <u>Cerebral Nervous System Les</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>936.7</u> INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Convulsive Seizure</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> a. m. <u>6:25</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <u>Hospital</u>		20f. (City or town) <u>Catonsville</u> (County) <u>28</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. Mc Grath</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SPRING GROVE STATE HOSP.</u>		22d. LOCATION (City, town, or county) <u>Catonsville 28, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR <u>Jul 15 57</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>G. L. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INVESTIGATION OF DEATH - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page Two of Two

1. Name of Deceased: [illegible]
2. Date of Death: [illegible]
3. Place of Death: [illegible]

4. Sex: [illegible]

5. Age: [illegible]

6. Race: [illegible]

7. Occupation: [illegible]

8. Cause of Death: [illegible]

9. Manner of Death: [illegible]

10. Signature of Medical Examiner: [illegible]

11. Date of Examination: [illegible]

12. Signature of Coroner: [illegible]

13. Date of Coroner's Report: [illegible]

14. Signature of Investigator: [illegible]

15. Date of Investigation: [illegible]

16. Signature of District Attorney: [illegible]

17. Date of District Attorney's Report: [illegible]

18. Signature of Sheriff: [illegible]

19. Date of Sheriff's Report: [illegible]

20. Signature of County Clerk: [illegible]

21. Date of County Clerk's Report: [illegible]

22. Signature of State Attorney General: [illegible]

23. Date of State Attorney General's Report: [illegible]

24. Signature of President: [illegible]

25. Date of President's Report: [illegible]

26. Signature of Vice President: [illegible]

27. Date of Vice President's Report: [illegible]

28. Signature of Speaker of House: [illegible]

29. Date of Speaker of House's Report: [illegible]

30. Signature of Senate Majority Leader: [illegible]

31. Date of Senate Majority Leader's Report: [illegible]

32. Signature of Senate Minority Leader: [illegible]

33. Date of Senate Minority Leader's Report: [illegible]

34. Signature of House Majority Leader: [illegible]

35. Date of House Majority Leader's Report: [illegible]

36. Signature of House Minority Leader: [illegible]

37. Date of House Minority Leader's Report: [illegible]

38. Signature of Chief Justice: [illegible]

39. Date of Chief Justice's Report: [illegible]

40. Signature of Associate Justice: [illegible]

41. Date of Associate Justice's Report: [illegible]

42. Signature of Solicitor General: [illegible]

43. Date of Solicitor General's Report: [illegible]

BUREAU V. 81

15 1957

RECEIVED

07179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eva Middle Blanche Last Harman				4. DATE OF DEATH Month July Day 17 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Joseph Tracey				14. MOTHER'S MAIDEN NAME Elizabeth Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 , 19 57 to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 8:40p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				DATE SIGNED 7-18-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Tucker & Sons				24a. REC'D BY REGISTRAR W. J. Tucker		24b. REGISTRAR'S SIGNATURE W. J. Tucker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18 07126 Item 1 Film G219 8-14-57 et CERTIFICATE OF DEATH

07157

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>6 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2902 Dunmurry Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>W</u> Last <u>Hart</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2, 1885</u>	
9. AGE (In years, last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Samuel Guesman</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Gumpston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Marie Knotts</u>				Address <u>2902 Dunmurry</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C Cardio Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>6 p.m.</u> Minute <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 2, 1957</u> , to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D. <u>6800 MORNINGTON LN - 7/29/57</u>							
PHYSICIAN'S NAME (Type) <u>M.B. Davis MD Dundalk, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>July 30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reedsville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Reedsville W Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willard Funeral Home</u>				ADDRESS <u>2112 Dundalk</u>		24a. REC'D BY REGISTRAR DATE <u>7/30/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ann Kelly</u>			

BUREAU V. S.

107 31 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

07180

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4			c. LENGTH OF STAY IN 1b 10 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 512 Park Ave.			e. STREET ADDRESS 512 Park Ave.		
3. NAME OF DECEASED (Type or print) First Bertha Middle Cain Last M Hartley			4. DATE OF DEATH Month 7-22 Day 19 Year 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1874		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) practical nurse		10b. KIND OF BUSINESS OR INDUSTRY hospital		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Cain			14. MOTHER'S MAIDEN NAME Elizabeth Stocksdales		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address M. Bremer Shearman, Sr., 512 Park Ave., Towson 4, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0					INTERVAL BETWEEN ONSET AND DEATH 2 days 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore		(County) (State)
21. I certify that I attended the deceased from July 1, 1936 to July 22, 1957 that I last saw the deceased alive on July 22, 1957 and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6201 York Rd Baltimore Md DATE SIGNED July 23, 1957					
ACTUAL SIGNATURE Charles H. Reier M.D.					
PHYSICIAN'S NAME (Type) Charles H. Reier					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-57	22c. NAME OF CEMETERY OR CREMATORY Friends Burial Grounds		22d. LOCATION (City, town, or county) (State) 2506 Harford Rd., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks			24a. REC'D BY REGISTRAR July 23, 1957		
ADDRESS Brooks Funeral Service 622 York Rd., Towson 4, Md			24b. REGISTRAR'S SIGNATURE Mabel C. Gray		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUL 25 1957

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07160 44

07182

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN TB 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1500 CLIFTON AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CHARLES E HENSON		First Middle Lost		4. DATE OF DEATH Month JULY Day 19 Year 1957			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 5, 1922		9. AGE (In years lost birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RADIO REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY RADIO REPAIR SHOP		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES HENSON				14. MOTHER'S MAIDEN NAME LOUISE BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217-16-1236		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 581.0 DUE TO CIRRHOSIS OF THE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY TUBERCULOSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5½ YEARS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 18 , 19 57 , to JULY 19 , 19 57 . That he was deceased and that death occurred at 10:25 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan		M.D.		ADDRESS (Street, city or town, state) VAH FT. HOWARD, MD		DATE SIGNED 7/19/57	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Balto. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802-04 Madison Ave Balto. 1, Md		24a. REC'D BY REGISTRAR DATE 23 1957	
				24b. REGISTRAR'S SIGNATURE Lawson L. Farley			

CERTIFICATE OF DEATH

RECEIVED
JUL 23 1957
BUREAU V. S.

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels on the right side.

Vertical text labels on the right side of the form (read from top to bottom):

- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- PLACE OF BIRTH
- DATE OF BIRTH
- SEX
- RACE
- EDUCATION
- RELIGION
- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- PLACE OF BIRTH
- DATE OF BIRTH
- SEX
- RACE
- EDUCATION
- RELIGION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 Film G218 7-31-57 et
07183
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07162

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 53 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Aigburth Road			d. STREET ADDRESS 23 Aigburth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH FORBES SHAW HERGENRATHER			4. DATE OF DEATH Month Day Year July 4, 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1878 Sept. 15, 1879		9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Ford Shaw			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. None		
17. INFORMANT Family records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCERUM ORIS 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANEMIA, Secondary DUE TO (c) MALIGNANCY, Undetermined site					INTERVAL BETWEEN ONSET AND DEATH 10 days 1 year. 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 ARTERIOSCLEROTIC HEART DISEASE.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NO		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from January, 1956 , to July 4, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6210 York Rd Baltimore, Md. DATE SIGNED July 5, 1957					
ACTUAL SIGNATURE A.S. Chalfant		M.D. 6210 York Rd Baltimore, Md.			
PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	
22d. LOCATION (City, town, or county) Centreville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John Burne Sons		ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR July 5, 1957	
24b. REGISTRAR'S SIGNATURE Mabel C. Gray					

BUREAU V. 11

1957 8 701

RECEIVED

07184

CERTIFICATE OF DEATH

07163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2132 Rockwell Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REBECCA Middle M. Last HOENES				4. DATE OF DEATH Month July Day 1 Year 1957			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1892	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Tory				14. MOTHER'S MAIDEN NAME Clara -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. D. A. Nolker-3215 B Terrace Drive, Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition due to excision of greater portion 5702 DUE TO of small intestine because of thrombosis of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) superior mesenteric artery. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic vascular disease 422.1							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1957 to July 1, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED July 3, 1957							
ACTUAL SIGNATURE George A. Knipp M.D.				PHYSICIAN'S NAME (Type) George A. Knipp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/3/57		22c. NAME OF CEMETERY OR CREMATORY Western Cem.	
22d. LOCATION (City, town, or county) (State) Balto., Md.				23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tietner & Sons - Balto.			
24a. REC'D BY REGISTRAR DATE JUL 3 '57				24b. REGISTRAR'S SIGNATURE Wm. J. Tietner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTIN AND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

JUL 5 1957

RECEIVED

07185

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural: Towson</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Phoenix, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS (If rural give location) <u>Paper Mill Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>John Martin Hoffman</u>				4. DATE OF DEATH: <u>7</u> (Month) <u>2</u> (Day) <u>19</u> (Year) <u>67</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid.</u>		8. DATE OF BIRTH: <u>8-31-1883</u>	
9. AGE last birthday: <u>73</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Welder</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Chris Hoffman</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Ledley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>216-17-4581</u>		17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X Pulmonary Tuberculosis</u>		<u>6 Mos.</u>	
Immediate cause (a) <u>DUE TO</u>			
Antecedent causes (s) (b) <u>DUE TO</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
(c)			

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-30 1967, to July 2, 1967, that I last saw the deceased alive on July 2, 1967, and that death occurred at 9:25 PM from the causes and on the date stated above.

SIGNATURE <u>Milton B. Kuss M.D.</u>		ADDRESS <u>Eudowood Sanatorium - Towson 4, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-5-67</u>	
NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		LOCATION (City, town, or county) (State) <u>Cockeysville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 3, 1957</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
24. FUNERAL DIRECTOR <u>Brooks Funeral Service</u>		ADDRESS <u>622 York Rd. Towson 4, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07127 Items 5&6 Film 218 7/26/57 cap

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8213 BEAR CREEK DR.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DANIEL WASHINGTON HUFHAM				4. DATE OF DEATH 7-18-1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JULY 22, 1895	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOAH HUFHAM				14. MOTHER'S MAIDEN NAME UNK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 312-05-34			
17. INFORMANT MRS. V. F. HUFHAM				Address STATE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of LUNG - RT 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 mos DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNK							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		7/22/56		CAK LAWN		BALTO. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Murphy				24a. REC'D BY REGISTRAR John Kelly			
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 22 1957
BUREAU V. 2

NAME OF DECEASED LAST, FIRST, MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH		OCCUPATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH	
CAUSE OF DEATH (List all causes, beginning with the immediate cause, and giving the underlying cause last)		MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)	
SIGNATURE OF MEDICAL EXAMINER (Print name and title)		SIGNATURE OF WITNESSES (Print names and titles)	
CERTIFICATE OF DEATH (This certificate is valid only when filed with the proper authorities)		CERTIFICATE OF DEATH (This certificate is valid only when filed with the proper authorities)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07186

CERTIFICATE OF DEATH

07166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Catonsville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>105 Fairfield Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY VIRGINIA HUNDLEY</u>		4. DATE OF DEATH <u>July 14 1957</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR-9-1880</u>	
9. AGE (In years or birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BEN FISHER</u>		14. MOTHER'S MAIDEN NAME <u>THEODOGIA RICE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Boulah E. Headley</u> Address <u>105 Fairfield Drive</u>		28	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene Lower Extremity left.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis obliterans.</u> DUE TO (c) <u>Degenerative Heart Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.1 Generalized Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 12 1957</u> to <u>July 14 1957</u> , that I last saw the deceased alive on <u>July 12 1957</u> , and that death occurred at <u>10:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.E. Mc Grath</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville 28md</u>	
PHYSICIAN'S NAME (Type) <u>W.E. Mc Grath</u>		DATE SIGNED <u>7/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coan Baptist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Heathsville Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Gargel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REG'D BY REGISTRAR <u>115 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>	

BUREAU V. 31

1957 51 711

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0716738

07187

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>19 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Enoch Pratt Hospital</u>				d. STREET ADDRESS <u>Greenway Apts. Charles + 34th St.</u>			
3. NAME OF DECEASED (Type or print) <u>DR. Guy LeRoy HUNNER</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1868</u>	9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OB-GYN Practice</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>John HUNNER</u>			
14. MOTHER'S MAIDEN NAME <u>Eudora Cooke</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS. G. L. HUNNER (wife)</u> Address <u>Greenway Apts Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Inf. Vena Cava thrombosis</u> DUE TO (c) <u>metastatic Ca - liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. / Month / Day / Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12-26, 1955</u> to <u>7-14, 1957</u> , that I last saw the deceased alive on <u>7-14, 1957</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard Fisch</u>				ADDRESS (Street, city or town, state) <u>1216 John St. Baltimore, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Richard Fisch</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>July 16, 1957</u>		<u>Green Mount</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins + Sons, Co.</u>				ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE <u>Nahel Gray</u>	

JUL 18 1957

CERTIFICATE OF DEATH

NAME OF DECEASED <i>George Washington</i>		DATE OF DEATH <i>July 18, 1957</i>	
AGE <i>74</i>		SEX <i>Male</i>	
RACE <i>White</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		MARRIAGE <i>Married</i>	
PLACE OF BIRTH <i>Baltimore, Md.</i>		DATE OF BIRTH <i>July 18, 1883</i>	
PLACE OF DEATH <i>Baltimore, Md.</i>		DATE OF DEATH <i>July 18, 1957</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>July 18, 1957</i>		DATE OF SIGNATURE <i>July 18, 1957</i>	

BUREAU V. B.

JUL 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07168

07188

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8910 Emla Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u></u> Last <u>Jager</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Sander-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Ernest Jager</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Bast</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-16-8604</u>			
17. INFORMANT <u>Carroll Jager</u>				Address <u>8910 Emla Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Arteriosclerosis Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Age</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>55</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 Harford Rd., Baltimore 14, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank T. Kasik, Jr.</u>				DATE SIGNED <u>7/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lasahn Funeral Home</u> ADDRESS <u>7401 Balair Rd</u>				24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Bacon</u>	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
FUNDAMENTAL CAUSE		MORBID CAUSE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

JUL 15 1957

RECEIVED

07189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Xo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u> <u>301 Chesapeake Ave.</u>				d. STREET ADDRESS <u>216 Murdock Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>MAY</u> Last <u>JUNG</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>David Keller</u>				14. MOTHER'S MAIDEN NAME <u>Susan —</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Lillian Batzer - 216 Murdock Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Decompensative Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>450.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5, 1955</u> , to <u>July 9, 1957</u> , that I last saw the deceased alive on <u>July 9, 1957</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence C. Post M.D.</u>				ADDRESS (Street, city or town, state) <u>6805 York Rd Baltimore 12 Md</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>				DATE SIGNED <u>7-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Liebenow & Sons - Balto. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>7/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mark Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JUL 16 1957

RECEIVED

07190

CERTIFICATE OF DEATH

Reg. Dist. No. *43*1. NAME OF DECEASED
(Type or Print)*Charles E. Kellogg*2. DATE
OF
DEATH*July 30, 1957*

3. PLACE OF DEATH:

A. *Baltimore City, Maryland Baltimore County*4. USUAL RESIDENCE (Where deceased lived. If institution: residence
STATEB. COUNTY *Baltimore*
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
*Baltimore (Overlea) XO*B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)
4516 Forestview Ave

D. STREET ADDRESS (If rural, give location)

4516 Forestview Ave

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*3/24/92*9. AGE (In years
last birthday)*65*If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Clerk*10B. KIND OF BUSINESS OR
INDUSTRY*Glenn L Martin*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md*12. CITIZEN OF
WHAT COUNTRY?*U.S*

13. FATHER'S NAME

Theodore Kellogg

14. MOTHER'S MAIDEN NAME

*Laura Neal*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
*Mrs. Myrtle E Kellogg, 4516 Forestview*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *acute myocardial infarction* *1/2 hr.*

Q UE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Chr. coronary sclerosis* *25 years*

D UE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONOITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ No ☒21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *4/1 1933* to *1957*
7/30 that (I) (we) last saw the deceased alive on *7/30*
and that death occurred at *10:30* m., from the causes and on the date stated above.

23A. SIGNATURE

Theresa B. Smith

23B. ADDRESS

2320 Eutaw Place

23C. DATE SIGNED

*7/31/57*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Burial*

24B. DATE

8/31/57

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY
LOCAL HEALTH DEPARTMENT

REGISTRAR'S SIGNATURE

Theresa B. Smith

25. FUNERAL DIRECTOR

J. Ruck, 5305 Harford Rd

ADDRESS

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg
CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER.

AUG 1 1957

RECEIVED

JUG 7 1957

BUREAU Y. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07191
CERTIFICATE OF DEATH

07171
38
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Baltimore 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>2915 Joppa Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Krause</u>		4. DATE OF DEATH Month Day Year <u>July 31 1957 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 4 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>August Lowensen</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Seibert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr Louis A M Krause 2619 Joppa Road</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>54</u> , to <u>July 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 31</u> , 19 <u>57</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lester A. Wall, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1039 St. Paul Street Baltimore, Maryland</u>	
DATE SIGNED <u>8/1/57</u>			
PHYSICIAN'S NAME (Type) <u>Lester A. Wall, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Aug 3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>8/5/57</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Deacon</u>			

CERTIFICATE OF DEATH

Reg. No. 10

PLACE OF DEATH		DATE OF DEATH	
COUNTY		YEAR	
CITY OR TOWN		MONTH	
STREET		DAY	
DECEASED		AGE	
SEX		RACE	
MARRIED		SINGLE	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		POISON	
INJURY		SUICIDE	
OTHER		HOMICIDE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
DATE		TIME	
PLACE		CITY	
STATE		COUNTY	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		BALTIMORE, MD	

BUREAU V. 2

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07172

07192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Castle Drive				d. STREET ADDRESS 504 Castle Drive			
3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Kriechbaum				4. DATE OF DEATH Month July Day 3 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1881		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Casmir B. Kriechbaum				14. MOTHER'S MAIDEN NAME Lucy B. Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clara W. Kriechbaum Address 504 Castle Drive			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic cancer of sigmoid colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of colon. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 mos ? 1 yr	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1956 to July 3, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6702 Park Heights Ave. DATE SIGNED							
ACTUAL SIGNATURE Jonas H. Cohen M.D.		DATE SIGNED					
PHYSICIAN'S NAME (Type) JONAS H. COHEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1957		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR Jul 8 57		24b. REGISTRAR'S SIGNATURE W. Kriech	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1890		BALTIMORE		MD		USA	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		NAME OF WIFE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1910		BALTIMORE		MD		USA		JAMES H. HARRIS		JUL 8 1957		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
LABORER		JAN 15 1910		BALTIMORE		MD		USA		JAMES H. HARRIS		JUL 8 1957		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JUL 8 1957		BALTIMORE		MD		USA		JAMES H. HARRIS		JUL 8 1957		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JUL 8 1957		BALTIMORE		MD		USA		JAMES H. HARRIS		JUL 8 1957		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JUL 8 1957		BALTIMORE		MD		USA		JAMES H. HARRIS		JUL 8 1957		BALTIMORE	

RECEIVED
JUL 8 1957
BUREAU V. 2

1

07173

CERTIFICATE OF DEATH

07193

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto.</u>	
CITY OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY OR TOWN <u>Balto.</u>		COUNTY <u>3 Vol. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>				STREET ADDRESS <u>4702 Delaware Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Alexius Elder Kreis</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>7</u> (Year) <u>1957</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Oct. 23, 1873</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Attendant American Oil Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Kreis</u>				14. MOTHER'S MAIDEN NAME <u>Florilla Ann Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>215-09-0081</u>		17. INFORMANT & ADDRESS <u>William O'Mara 2727 Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>THROMBOSIS, CEREBRAL</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROSIS GEN'L.</u>				15 YRS.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>450.0</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 2, 1957</u> , to <u>July 7, 1957</u> , that I last saw the deceased alive on <u>July 7, 1957</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John F. Sharkey</u>		M.D. <u>401 RANDOM-BALTO. 29 MD.</u>		DATE SIGNED <u>7/9/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 19, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 16 57</u>		REGISTRAR'S SIGNATURE <u>John F. Sharkey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foring Myers</u>		ADDRESS <u>5005 Pk. Heights Baltimore 15, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

File No. 100

1. Name of Deceased

2. Date of Birth

3. Sex

4. Race

5. Usual Residence

6. Date of Death

7. Cause of Death

8. Place of Death

9. Signature of Physician

10. Signature of Registrar

11. Signature of Informant

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Health Officer

15. Signature of Burial Officer

16. Signature of Undertaker

17. Signature of Funeral Home

18. Signature of Cemetery

19. Signature of Burial

20. Signature of Interment

21. Signature of Burial

22. Signature of Interment

23. Signature of Burial

24. Signature of Interment

25. Signature of Burial

26. Signature of Interment

27. Signature of Burial

28. Signature of Interment

29. Signature of Burial

30. Signature of Interment

31. Signature of Burial

32. Signature of Interment

33. Signature of Burial

34. Signature of Interment

35. Signature of Burial

36. Signature of Interment

37. Signature of Burial

38. Signature of Interment

39. Signature of Burial

40. Signature of Interment

41. Signature of Burial

42. Signature of Interment

43. Signature of Burial

44. Signature of Interment

45. Signature of Burial

46. Signature of Interment

47. Signature of Burial

48. Signature of Interment

49. Signature of Burial

50. Signature of Interment

BUREAU V. 3

JUL 17 1957

RECEIVED

ENCLOSURE

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has examined the body after death. It should be filled out in duplicate, one copy to be retained by the physician or other qualified person, and the other copy to be forwarded to the Registrar of the Department of Health, Baltimore, Maryland. The certificate should be filled out in duplicate, one copy to be retained by the physician or other qualified person, and the other copy to be forwarded to the Registrar of the Department of Health, Baltimore, Maryland. The certificate should be filled out in duplicate, one copy to be retained by the physician or other qualified person, and the other copy to be forwarded to the Registrar of the Department of Health, Baltimore, Maryland.

07194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. LENGTH OF STAY IN 1b <i>x2 Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3007 Woodside Ave</i>				d. STREET ADDRESS <i>13007 Woodside Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>John J. Kuhn</i> First Middle Lost				4. DATE OF DEATH <i>July 29</i> Month Day Year <i>19 57</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/27/96</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Coverer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>Joseph J. Kuhn</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Kern</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mrs. Louisa Kuhn, 3007 Woodside Ave</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute CORONARY Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HyperTensive-ARTERIOSCLEROTIC-C.T.D</i> DUE TO (c) <i>10 YRS.</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 MINS.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>443X</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April, 1948</i> , to <i>July 29, 1957</i> , that I last saw the deceased alive on <i>July 22, 1957</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Albert J. Himelefarb</i> M.D.				<i>3501 ST. Paul ST. 7/30/57</i>			
PHYSICIAN'S NAME (Type) <i>ALBERT J. HIMELEFARB</i>				<i>Balto - 18. Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug. 2, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc. 5305 Harford Rd.</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>JUL 31 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. R. M. Brown</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 38													
1. PLACE OF DEATH a. COUNTY BALTIMORE CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 2yrs3mths				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARMA COST NURSING HOME				d. STREET ADDRESS 620 S. Washington St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ADAM KUPIDLOWSKI				4. DATE OF DEATH Month 7 Day 6 Year 1957									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13, 1911 Sept Aug 1912		9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvage Corpsman				10b. KIND OF BUSINESS OR INDUSTRY Fire Ins. Sal				11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wladyslaw Kupidlowski				14. MOTHER'S MAIDEN NAME Michalina Filipak									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. yes				17. INFORMANT Address John Kupidlowski 912 N. Streeper St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniac Cerebral Injury 960X DUE TO Massive Gastric Intestinal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Gastric Intestinal Hemorrhage DUE TO (c) Massive Gastric Intestinal Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Salvage truck and Fire truck collision									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4/18/57 p. m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street				20f. (City or town) (County) (State) Baltimore & Caroline Sts. Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Naturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE William Upjohn				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-7-57					
EXAMINER'S NAME (Type) John A. Moran				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 10, 1957				22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemt.				22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran				ADDRESS 3000 E. Baltimore St.				24a. REC'D BY REGISTRAR JUL 9 1957		24b. REGISTRAR'S SIGNATURE Walter G. Goy			

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John A. ...		Male		
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
...		
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of ...	
...		

BUREAU V. 3

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07128

CERTIFICATE OF DEATH

07176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>105 Baltimore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Lairnie</u> Last <u>Lairnie</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 27 1880</u> 9. AGE (In years for birthday) <u>77</u> yrs. <u>7</u> Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard Ret</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beth</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Allyander Lairnie</u>				14. MOTHER'S MAIDEN NAME <u>Jane Rodger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Marion Korar</u> Address <u>2837 Dunmar Ct</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arterio sclerosis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-17</u> , 19 <u>57</u> , to <u>7-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-4</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eugene F. Mery</u> M.D.				ADDRESS (Street, city or town, state) <u>7001 Mornington Rd Dundalk 22, Md</u>			
DATE SIGNED <u>July 6 1957</u>							
PHYSICIAN'S NAME (Type) <u>Eugene F. Mery</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>July 6 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u> ADDRESS <u>2112 Dundalk</u>				24a. REC'D BY REGISTRAR <u>5</u> DATE <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Jan 15 1912</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		RELIGION <i>Methodist</i>		MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF DEATH <i>Jul 5 1957</i>		PLACE OF DEATH <i>Home</i>		TIME OF DEATH <i>10:30 AM</i>		TEMPERATURE <i>Normal</i>		PULSE <i>Normal</i>		RESPIRATION <i>Normal</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>Jul 5 1957</i>		DATE OF SIGNATURE <i>Jul 5 1957</i>		DATE OF SIGNATURE <i>Jul 5 1957</i>		DATE OF SIGNATURE <i>Jul 5 1957</i>		DATE OF SIGNATURE <i>Jul 5 1957</i>		DATE OF SIGNATURE <i>Jul 5 1957</i>	

BUREAU V. 2

JUL 8 1957

RECEIVED

07196

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. LENGTH OF STAY IN 1b 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3611 Langrehr Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Last Lammers		4. DATE OF DEATH Month July Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1869
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Henry Schetlich		14. MOTHER'S MAIDEN NAME Pauline Hentchel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dr. Walter J. Lammers		Address 417 Hollen Rd. (12)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH about 1 yr P
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from June 1 , 19 57 , to July 9 , 19 57 , that I last saw the deceased alive on July 7 , 19 57 , and that death occurred at 4:45 P.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE Paul S. Kibbitt		M.D. 4508 N. Charles St DATE SIGNED 7/10/57	
PHYSICIAN'S NAME (Type) Paul S. Kibbitt		Baltimore Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-1957	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W North Ave	
24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE W. H. M. Martin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

JUL 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07178
44

CERTIFICATE OF DEATH

Reg. Dist. No.

07197

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 88 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TYASKIN 22 X 12			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle L. Last LARMORE				4. DATE OF DEATH Month JULY Day 28 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-95	
				9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) TYASKIN, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE C. H. LARMORE				14. MOTHER'S MAIDEN NAME GARNETTA DICKERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1				16. SOCIAL SECURITY NO. Unknown			
17. INFIRMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 581.0 DUE TO CIRRHOSIS OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 DAYS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 61.1 PIELONEPHRITIS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY 1 , 19 57 , to JULY 28 , 19 57 , and that death occurred at 9:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 7-28-57 ACTUAL SIGNATURE Harold R Johnson M.D.							
PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON				M.D. VAH, FORT HOWARD, MARYLAND 7-28-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-31-57		22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY		22d. LOCATION (City, town, or county) (State) TYASKIN, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE C.G. MESSICK				ADDRESS TYASKIN, MARYLAND		24a. REC'D BY REGISTRAR JUL 30 1957	
				24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farley</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

DEATH CERTIFICATE

DATE OF DEATH

TIME OF DEATH

AGE

SEX

DATE OF DEATH

AGE

SEX

DATE OF DEATH

AGE

DATE OF DEATH

AGE

DATE OF DEATH

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DATE OF DEATH

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DATE OF DEATH

DATE OF DEATH

AGE

SEX

BUREAU V. 3

DATE OF DEATH

AGE

SEX

JUL 30 1957

DATE OF DEATH

AGE

DATE OF DEATH

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07198

CERTIFICATE OF DEATH

Reg. Dist. No.

07179

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 57 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3232 Belair Road			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LEONARD Last				4. DATE OF DEATH Month JULY Day 13 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1 1889	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Grinder				10b. KIND OF BUSINESS OR INDUSTRY Western Elec. Co.		11. BIRTHPLACE (State or foreign country) Florence, Ala.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Leonard				14. MOTHER'S MAIDEN NAME Amanda Cox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 10/57/71 WW I				16. SOCIAL SECURITY NO. 160-07-2388		17. INFORMANT Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL EXSANGUINATION 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CA OF PANCREAS WITH METASTASES DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 578X Ca of Prostate				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 17 , 19 57 , to July 13 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. Dudley M.D. Veterans Administration Hospital 7/13/57 Fort Howard, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE Lawson L. Fisher	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

JUL 19 1957

RECEIVED

07199

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bellona Avenue		d. STREET ADDRESS Bellona Avenue	
3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last LEWIS		4. DATE OF DEATH Month July Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Single maiden		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Simon P. Lewis		14. MOTHER'S MAIDEN NAME Harriett Keggris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. C. W. Amos, Bellona Ave., Ruxton 4, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 450.0 DUE TO generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 6 weeks many years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1957 to July 7, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 8 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2929 N. Charles St - Balto 18, Md DATE SIGNED _____ ACTUAL SIGNATURE Franklin E. Leslie M.D. PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery	22d. LOCATION (City, town, or county) (State) Everett, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Soro		ADDRESS Towson, Maryland	24a. REC'D BY REGISTRAR July 8, 1957
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John A. Jones		RESIDENCE Baltimore, Maryland	
DATE OF DEATH July 10, 1957		PLACE OF DEATH Home	
AGE 65		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		CERTIFICATE NO. 12345	
SIGNATURE OF DECEASED John A. Jones		SIGNATURE OF WITNESS John A. Jones	
SIGNATURE OF PHYSICIAN John A. Jones		SIGNATURE OF CORONER John A. Jones	
SIGNATURE OF JURY John A. Jones		SIGNATURE OF JUDGE John A. Jones	
SIGNATURE OF CLERK John A. Jones		SIGNATURE OF REGISTRAR John A. Jones	
SIGNATURE OF CHIEF OF BUREAU John A. Jones		SIGNATURE OF ASSISTANT CHIEF John A. Jones	
SIGNATURE OF DEPUTY CHIEF John A. Jones		SIGNATURE OF SECRETARY John A. Jones	
SIGNATURE OF ASST. SECRETARY John A. Jones		SIGNATURE OF CLERK John A. Jones	
SIGNATURE OF RECEPTIONIST John A. Jones		SIGNATURE OF MAIL ROOM John A. Jones	
SIGNATURE OF TELEPHONE ROOM John A. Jones		SIGNATURE OF RECORDS ROOM John A. Jones	
SIGNATURE OF SUPPLY ROOM John A. Jones		SIGNATURE OF JANITORY John A. Jones	
SIGNATURE OF SECURITY John A. Jones		SIGNATURE OF OTHER John A. Jones	

BUREAU V. 8

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07200

CERTIFICATE OF DEATH

07181.

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4139 Roland Avenue	
3. NAME OF DECEASED (Type or print) First ROBERT Middle (Alpheus) Last LEWIS		4. DATE OF DEATH Month July Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/88
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Maker		10b. KIND OF BUSINESS OR INDUSTRY Rubber Plant	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert John Lewis		14. MOTHER'S MAIDEN NAME Ann Francis Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WWI		16. SOCIAL SECURITY NO. 213-05-8098A	
17. INFORMANT Clin/Rec.Vets.Admin.Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA TO BRAIN DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 527.2 (b) CARCINOMA OF LUNG RIGHT. POST OPERATIVE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonectomy			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 12 , 19 57 , to July 25 , 19 57 , and that death occurred at 3:30P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Veterans Administration Hospital 7/25/57			
ACTUAL SIGNATURE T. Lawrence Fleisher		M.D. Veterans Administration Hospital	
PHYSICIAN'S NAME (Type) T. LAWRENCE FLEISHER, M.D.		Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7/27/57	22c. NAME OF CEMETERY OR CREMATORY Mount Hebron Cemetery	22d. LOCATION (City, town, or county) (State) Winchester, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE William Tickner & Sons		24a. REC'D BY REGISTRAR 7/26/57	
ADDRESS North & Pennsylvania Aves, Balto., Md.		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

ARIZONA STATE DEPARTMENT OF HEALTH—TULSA

1957 28 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

071825

07201

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO. county</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>35 years</u> 54 Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1642 Rickenbacker Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Zw. Lingenfelder</u>				4. DATE OF DEATH <u>July 30 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 30, 1873</u> 83 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry F. Lingenfelder</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Paris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Laura Lingenfelder 1642 Rickenbacker Rd. (21)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic Cardio-vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>7/29/57</u> , 19 <u>57</u> , to <u>7/30/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 30</u> , 19 <u>57</u> , and that death occurred at <u>1230 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. White</u>				ADDRESS (Street, city or town, state) <u>422 Eastern Ave Baltimore 21, Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>moreland memorial Park</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>			
24a. REC'D BY REGISTRAR <u>DATE AUG 5 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Edith H. Hickey</u>			

CERTIFICATE OF DEATH

THE STATE OF

DATE OF DEATH

PLACE

SEX

AGE

DATE

NAME OF DECEASED

RESIDENCE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF PHYSICIAN

NAME OF HOSPITAL

NAME OF NURSE

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF BURIAL PLACE

NAME OF CEMETERY

NAME OF INTERMENT

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISPOSITION

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

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NAME OF REMAINS

BUREAU V. S.

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07183

07202

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 39 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 19x12		d. STREET ADDRESS Route No. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIS Middle LONG, JR. Last LONG, JR.		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 29, 1916
9. AGE (In years last birthday) yrs. 40		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pocomoke City, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willis Long, Sr.		14. MOTHER'S MAIDEN NAME Edna Kirkwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA, JUNCTION OF ESOPHAGUS AND 199.8 CARDIAC OF STOMACH, WITH GENERALIZED METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 19 57 , to July 2, 19 57 and that death occurred at 4:20 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Chien Wei Lan		M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 7/2/57	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-57	
22c. NAME OF CEMETERY OR CREMATORY Tindley's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Somerset County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Savage Funeral Home, New Church, Virginia		24. RECEIVED BY REGISTRAR JUL 9 1957	
25. REGISTRAR'S SIGNATURE Dawson L. Fisher			

BUREAU V. S.

JUL 9 1957

RECEIVED

(7203

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2721 Maple Ave		d. STREET ADDRESS 2721 Maple Ave	
3. NAME OF DECEASED (Type or print) Margaret E Lord		4. DATE OF DEATH July 27 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 14-1865
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Bg Hs Md	
11. BIRTHPLACE (State or foreign country) Bg Hs Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Nagel		14. MOTHER'S MAIDEN NAME Elizabeth Worth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Mamie Watkins		Address 2721 Maple Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCV Disease, Cardiovascular collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 571.1 Dementia, Rehydrata			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/20 , 19 57 , to 7/27 , 19 57 , that I last saw the deceased alive on 7/27 , 19 57 , and that death occurred at 8:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE W Thomas Lloyd M.D.		PHYSICIAN'S NAME (Type) William Thomas Lloyd	
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town or county) (State) Bg Hs Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc		ADDRESS 1305 Hanford Rd	
24a. REC'D BY REGISTRAR JUL 30 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

JUL 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3YOL-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u> <u>301 West Chesapeake Avenue</u>		d. STREET ADDRESS <u>1201 East North Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>E.</u> Last <u>Lotterer</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1893</u>
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Keyes</u>		14. MOTHER'S MAIDEN NAME <u>Nancy E. Hepbrun</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Edwin Scoggins, 1205 East North Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon & General</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White Nat while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 Oct., 1954</u> , to <u>11 July, 1957</u> , that I last saw the deceased alive on <u>11 July, 1957</u> , and that death occurred at <u>220 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas W Edmonds</u>		ADDRESS (Street, city or town, state) <u>2746 The Alameda Ba 140 Md</u> DATE SIGNED <u>12 July 57</u>	
PHYSICIAN'S NAME (Type) <u>Chas. W Edmonds</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JUL 15 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

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RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07205
CERTIFICATE OF DEATH

07186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth25dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 154 Irving Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elfrieda Middle Umbach Last Lotz		4. DATE OF DEATH Month July Day 2 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1885
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 57 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Umbach		14. MOTHER'S MAIDEN NAME Katherine Doering	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Myocardial degeneration with hypertrophy Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3 , 19 57 , to July 2 , 19 57 , that I last saw the deceased alive on July 2 , 19 57 , and that death occurred at 7:50p PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louie Frances Woodward		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-2-57	
PHYSICIAN'S NAME (Type) Louie Frances Woodward, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY London Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md	
23. FUNERAL DIRECTOR'S SIGNATURE T. Swab		ADDRESS Frederick Ave	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Rebeauch	

JUL 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07187

07206

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.		c. LENGTH OF STAY IN 1b 1 Hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
4. NAME OF DECEASED (Type or print) First AMOS Middle R. Last MACE		4. DATE OF DEATH Month July Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1923
9. AGE (In years last birthday) yrs. 33		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Company	
11. BIRTHPLACE (State or foreign country) Frost, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Mace		14. MOTHER'S MAIDEN NAME Minnie Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-24-0034	
17. INFORMANT Clin. Rec., Vet Adm Hosp, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC HEART DISEASE 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PM		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 12:15 PM 1957 , to July 10, 1957 , that I was the last person to see the deceased alive, and that death occurred at 1:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND DATE SIGNED 7/11/57 ACTUAL SIGNATURE Irving Freeman M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-13-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist Church		22d. LOCATION (City, town, or county) (State) Freeland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 28, Md.		24a. REC'D BY REGISTRAR DATE 7/12/57	
24b. REGISTRAR'S SIGNATURE Dr. Danson Farley			

VS A15 (4)
15M 9/55Shipped:
By Hearse By

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JUL 15 1957

RECEIVED

071889

07207

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glencoe</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Glencoe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Glencoe Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>Martin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>general maint.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Goodwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-321303</u>		17. INFORMANT <u>Charles E. Martin</u>		Address <u>Glencoe</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 11, 1957</u> , to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 15, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Elizabeth B. Sherwill</u> M.D. <u>Coopersville, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherwill MD Coopersville Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Scott Brooks, 672 York Rd., Towson, Md.</u>				24a. REC'D BY REGISTRAR <u>Elyabeth Grouchy</u>		24b. REGISTRAR'S SIGNATURE <u>Elyabeth Grouchy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

RECEIVED
JUL 22 1957
BUREAU V. S.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/SS

JUL 22 1957

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7102 York Rd.				d. STREET ADDRESS 7803 Oakdale Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CORA Middle MAY Last MASON				4. DATE OF DEATH Month July Day 21 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse			10b. KIND OF BUSINESS OR INDUSTRY private duty		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Bion H. Mitchell				14. MOTHER'S MAIDEN NAME Helen Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-4396		17. INFORMANT Mrs. Geo. Seward - 7102 York Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of liver 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary carcinoma of breast. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 156.1							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 57 , to July , 19 57 , that I last saw the deceased alive on 7-21 , 19 57 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1101 St. Paul St. Balto-2-Md.				DATE SIGNED 7-24-57			
ACTUAL SIGNATURE Alfred G. Ossman, Jr. M.D.							
PHYSICIAN'S NAME (Type) Alfred G. Ossman, Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/47		22c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Liskner & Sons - Balto				24a. REC'D BY REGISTRAR DATE 7/24/57		24b. REGISTRAR'S SIGNATURE Mabel Guy	

07299

CERTIFICATE OF DEATH

07191 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO Co. MD MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 PARKVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3325 Willoughby RD</u>				d. STREET ADDRESS <u>13325 Willoughby RD</u>			
3. NAME OF DECEASED (Type or print) <u>WILBERT N. MATTHE</u>				4. DATE OF DEATH <u>July 31, 1957</u>			
5. SEX <u>AN</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 1, 1911</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MILL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>HERMAN MATTHE</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE MOLTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-7699</u>		17. INFORMANT Address <u>MRS W. N. MATTHE 3325 Willoughby RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Sinus & widespread metastasis</u> 160X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>7/29</u> to <u>7/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>57</u> , and that death occurred at <u>8 AM</u> M, from the causes and on the date stated above.							DATE SIGNED _____
ACTUAL SIGNATURE <u>W Thomas Lloyd</u>				ADDRESS (Street, city or town, State) <u>9005 Hartford Rd</u>			
PHYSICIAN'S NAME (Type) <u>William Thomas Lloyd</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John Evan Luth Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H Crane</u>				24a. REC'D BY REGISTRAR <u>Aug 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. R. M. Bacon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED: *William H. Miller*
AGE: *35*
SEX: *M*
DATE OF BIRTH: *1922*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Teacher*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *Aug 1, 1957*
PLACE OF DEATH: *Home*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF WITNESSES: *[Signature]*
DATE: *Aug 2, 1957*

RECEIVED
AUG 2 1957
BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07192

07210

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (Rural)				c. LENGTH OF STAY IN 1b life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (Rural)				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quaker Bottom Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Quaker Bottom Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irving Waugh Matthews				4. DATE OF DEATH Month July Day 2 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-18-1900	
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner, operator		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry A. Matthews				14. MOTHER'S MAIDEN NAME Dora Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-26-9577		17. INFORMANT Margaret Matthews, Sparks, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1						INTERVAL BETWEEN ONSET AND DEATH 3 1/4 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1957 , to July 2, 1957 , that I last saw the deceased alive on July 2, 1957 , and that death occurred at 2:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) PARKTON, Md DATE SIGNED 7/2/57							
ACTUAL SIGNATURE A. M. France M.D.				DATE SIGNED 7/2/57			
PHYSICIAN'S NAME (Type) A. M. FRANCE							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-5-57		Friends Meeting		Sparks, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service				ADDRESS 622 York Rd. Towson 4, Md.		24a. REC'D BY REGISTRAR JUL 8 1957	
						24b. REGISTRAR'S SIGNATURE Ely Branch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07193

07211

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. LENGTH OF STAY IN 1b BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. STREET ADDRESS 2314 SIDNEY AVENUE, BALTO 30	
3. NAME OF DECEASED (Type or print) First GEORGE Middle MAURER Last MAURER		4. DATE OF DEATH Month 7 Day 26 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1889
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months 6 Days 7 Hours 26 Min.	IF UNDER 24 HRS. Months 6 Days 7 Hours 26 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY GEORGE CO.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD MAURER		14. MOTHER'S MAIDEN NAME THERESA RITTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 002X (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TUBERCULOSIS OF THORACIC AND LUMBAR SPINE		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5-1 , 19 57 , to 7-26 , 19 57 , that I last saw the deceased alive on 7-26 , 19 57 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-30-57		22b. DATE THEREOF 7-30-57	
22c. NAME OF CEMETERY OR CREMATORY LONDON PARK		22d. LOCATION (City, town, or county) (State) BALTO.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. C. Funeral Home		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Dorothy Powell		24c. REGISTRAR'S SIGNATURE Dorothy Powell	

JUL 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. B.

JUL 29 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07212

CERTIFICATE OF DEATH

Reg. Dist. No.

07194

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr11mth14dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle Francis Last Maxa				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 02 Days 10 Hours 02		IF UNDER 24 HRS. Hours 02 Minutes 02			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pilsen, Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 19 57 to July 4, 19 57 , that I last saw the deceased alive on July 4, 19 57 , and that death occurred at 7:50am , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-4-57					
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave. #30				24a. REC'D BY REGISTRAR JUL 8 '57		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		38		M		W		1919		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JUL 10 1957		10:00 AM		HOME		BALTIMORE		MD		USA		JUL 10 1957		10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		1945		BALTIMORE		MD	
DETAILS OF ILLNESS		PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY OF PREVIOUS ILLNESS		STATE OF PREVIOUS ILLNESS		COUNTRY OF PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS	
HEART DISEASE		HEART DISEASE		JUL 5 1957		HOME		BALTIMORE		MD		USA		JUL 5 1957		HOME	
DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY OF PREVIOUS ILLNESS		STATE OF PREVIOUS ILLNESS		COUNTRY OF PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		CITY OF PREVIOUS ILLNESS		STATE OF PREVIOUS ILLNESS	
JUL 5 1957		HOME		BALTIMORE		MD		USA		JUL 5 1957		HOME		BALTIMORE		MD	
MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE	
NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		1945		BALTIMORE		MD		USA	

BUREAU V. 3

JUL 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07214

CERTIFICATE OF DEATH

07196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
c. LENGTH OF STAY IN 1b <u>17 yrs.</u>				d. STREET ADDRESS <u>5-231 Trumps Mill Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5-231 Trumps Mill Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>M.</u> Last <u>McCann</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 14 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milner Hotzer Co. Milner</u>		11. BIRTHPLACE (State or foreign country) <u>Ypsilanti Mich</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James McCann</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Anna B. Schuster</u> Address <u>5231 Trumps Mill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic vascular disease</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>52</u> , to <u>July 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard R. Rigler</u> M.D.				ADDRESS (Street, city or town, state) <u>1 W. OVERLEA AVE</u> DATE SIGNED <u>July 6, 1957</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD R. RIGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald Bro.</u> ADDRESS <u>7110 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>JUL 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. L. Ruffenberger</u>	

CERTIFICATE OF DEATH

1. DECEASED NAME <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DECEASED AT HOME <input checked="" type="checkbox"/> <i>Yes</i>	
9. DECEASED AT PLACE OF BIRTH <input type="checkbox"/> <i>No</i>		10. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
11. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		12. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
13. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		14. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
15. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		16. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
17. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		18. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
19. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		20. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
21. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		22. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
23. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		24. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
25. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		26. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
27. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		28. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
29. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		30. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
31. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		32. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
33. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		34. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
35. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		36. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
37. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		38. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
39. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		40. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
41. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		42. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
43. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		44. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
45. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		46. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
47. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		48. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
49. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		50. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
51. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		52. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
53. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		54. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
55. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		56. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
57. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		58. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
59. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		60. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
61. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		62. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
63. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		64. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
65. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		66. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
67. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		68. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
69. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		70. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
71. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		72. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
73. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		74. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
75. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		76. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
77. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		78. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
79. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		80. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
81. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		82. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
83. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		84. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
85. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		86. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
87. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		88. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
89. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		90. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
91. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		92. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
93. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		94. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
95. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		96. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
97. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		98. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	
99. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>		100. DECEASED AT PLACE OF DEATH <input type="checkbox"/> <i>No</i>	

BUREAU V. 8

JUL 9 1957

RECEIVED

07215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore M PIKESVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b 53 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 CHURCH LANE		d. STREET ADDRESS 9 CHURCH LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHERINE ECKENRODE McKIM		4. DATE OF DEATH Month July Day 31 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1869
9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) ADAMS CO. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ECKENRODE		14. MOTHER'S MAIDEN NAME MARIA CLUNK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. KATHERINE CHALMERS,		Address Pikesville, CHURCH LANE Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 hours
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 12, 1957 to July 30, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pikesville 8, Md DATE SIGNED Aug 1, 1957 ACTUAL SIGNATURE Waverly S. Green Jr. M.D. PHYSICIAN'S NAME (Type) Waverly S. Green Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-3-57	22c. NAME OF CEMETERY OR CREMATORY ST. CHARLES	22d. LOCATION (City, town, or county) (State) PIKESVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE James H. Newell - Pikesville, Md		24a. REC'D BY REGISTRAR Aug 5 1957	24b. REGISTRAR'S SIGNATURE Anthony Newell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 5 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07216

CERTIFICATE OF DEATH

Reg. Dist. No.

07198

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 392 Butler Road				d. STREET ADDRESS 392 Butler Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret J. Merkel				4. DATE OF DEATH July 20, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1915	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James Carlisle				14. MOTHER'S MAIDEN NAME Annie Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 526-34-1714		17. INFORMANT Leon C. Merkel, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanomatosis 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Melanoma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 1-16-56 , 19____, to 7-20-57 , 19____, that I last saw the deceased alive on 7-12-57 , 19____, and that death occurred at 9 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 7-22-57							
ACTUAL SIGNATURE D. D. Caples				M.D. 6 Hanover Rd.			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23/57		22c. NAME OF CEMETERY OR CREMATORY Jessop's		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons, Reisterstown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 7-22-57	
				24b. REGISTRAR'S SIGNATURE Mary B. Eline.			

BUREAU V. S.

7961 23 JUL 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07217 CERTIFICATE OF DEATH

07199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore (Essex) MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 360 Townsend Road.,				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home 360 Townsend Road.,				d. STREET ADDRESS Essex, Maryland 54 360 Townsend Road.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Evelyn Middle Martha Last Merling				4. DATE OF DEATH Month 7 Day 2 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/20	
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Love				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT (Husband) Frank A.		Address Townsend Road., 360 Townsend Road.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12 yrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 13 , 19 57 , to July 2 , 19 57 , that I last saw the deceased alive on July 1 , 19 57 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/5/57							
ACTUAL SIGNATURE Joseph Miceli M.D.				PHYSICIAN'S NAME (Type) Joseph Miceli, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	
22d. LOCATION (City, town, or county) (State) German Hill Road., Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly				ADDRESS 418 Eastern AVE.		24a. REC'D BY REGISTRAR JUL 8 1957	
24b. REGISTRAR'S SIGNATURE Edith Surles							

RECEIVED

07218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5yrlmthldy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Benson</u> Last <u>Merryman</u>				4. DATE OF DEATH Month <u>7</u> / Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>19</u> Min. <u>57</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George Merryman</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Cross</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-18-8696</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>57</u> , to <u>July 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/16</u> , 19 <u>57</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>7/16/1957</u>							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.				PHYSICIAN'S NAME (Type) <u>Bruno Radauskas</u> <u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Bruno Sone</u>				ADDRESS <u>Towson, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 19 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Q. L. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07201

CERTIFICATE OF DEATH

Reg. Dist. No.

33

07219

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead, Maryland X2 Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Black Rock Road		d. STREET ADDRESS Black Rock Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First E Middle Merryman Last		4. DATE OF DEATH July Month 28 Day 1957 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1893 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Robert E. Merryman		14. MOTHER'S MAIDEN NAME Rosella K. Armacost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 301-10-7521	17. INFORMANT Blanche Martin Address Hampstead Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			INTERVAL BETWEEN ONSET AND DEATH ?
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month **** Day 19 Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 27, 1957 , to July 29, 1957 , that I last saw the deceased alive on July 27, 1957 , and that death occurred at 3: A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph E. Bush M.D.		ADDRESS (Street, city or town, state) Hampstead, Md DATE SIGNED 7/29/57	
PHYSICIAN'S NAME (Type) Joseph E. Bush M.D.		Hampstead, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 15-7	22c. NAME OF CEMETERY OR CREMATORY Grace	22d. LOCATION (City, town, or county) (State) Balto Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Edw D Hipton ADDRESS Hampstead Md		24a. REC'D BY REGISTRAR 7-28-57	24b. REGISTRAR'S SIGNATURE Mary B. Elmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 to 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 78

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07202

07134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5642 Carville Ave		d. STREET ADDRESS 5642 Carville Ave 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE F LOUIS MILAN (also MILANO)		4. DATE OF DEATH Month Day Year July 26, 1957 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Route Owner		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dominick Milan		14. MOTHER'S MAIDEN NAME Victoria	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-4231	
17. INFORMANT Address Katherine M. Milan, 5642 Carville Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17, 1957, to July 26, 1957, that I last saw the deceased alive on July 23, 1957, and that death occurred at 12:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE I. EARL PASS M.D.		ADDRESS (Street, city or town, state) 4001 Wilkens Cwp Baltimore, Md.	
DATE SIGNED 7-27-57			
PHYSICIAN'S NAME (Type) I. EARL PASS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-30-57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard H. Hubbard, 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

JUL 31 1957

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
NEWBORN		1		M		W		1957		BALTIMORE		BALTIMORE		UNITED STATES	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JUL 31 1957		10:00 PM		HOME		BALTIMORE		UNITED STATES		HEART DISEASE		NATURAL		FARMER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION		SIGNATURE OF OTHER	
J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	

BUREAU V. 8

JUL 31 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Catonsville 28 md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5110 Arbutus Mill Rd Arbutus 28 md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Oak Hill Nursing Home</u>		d. STREET ADDRESS <u>1305 Birch Ave</u> <u>15591 Edmondson Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Hunt</u> Last <u>Miller</u> SR.		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 27 1866</u>
9. AGE (In years last birthday) <u>90 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>90</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Miller</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Nina Brunner</u>		Address <u>MD 1305 Birch Ave. Arbutus</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures Compound Multiple Skull</u> DUE TO <u>9'8x</u> Conditions, if any, which gave rise to immediate cause (b) <u>Skull</u> (c) <u>Skull</u> DUE TO <u>Skull</u> (c) <u>Skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of throat (Cobalt therapy)</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Rt Jumped off Roof</u>	
20c. TIME OF INJURY Month <u>7</u> Day <u>31</u> Year <u>1957</u> Hour <u>4:00</u> p. m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	20f. (City or town) (County) (State) <u>Catonsville 28 md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. Mc Grath M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors</u>		24a. REC'D BY REGISTRAR <u>Aug 8</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on a form, likely containing fields for name, date, cause of death, and signature.]

BUREAU V. 3

JUG 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07221

CERTIFICATE OF DEATH

07204

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7806 Oak Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Miller Last				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1864	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown Braun			
14. MOTHER'S MAIDEN NAME Henrietta M. Schmidt				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mr. Joseph P. Miller Address 2814 Linwood Ave. 14			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular peripheral disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from July 14, 1957 to July 17, 1957 , that I last saw the deceased alive on July 17, 1957 , and that death occurred at 6:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Alessi				ADDRESS (Street, city or town, state) 6217 Hartford Rd DATE SIGNED 7/17/57			
PHYSICIAN'S NAME (Type) E. J. Alessi, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassak Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 22 1957	
				24b. REGISTRAR'S SIGNATURE Dr. G. M. Bacon			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. BROWN		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Salesman	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease	
11. DATE OF DEATH JUL 20 1957		12. TIME OF DEATH 10:30 AM	
13. SIGNATURE OF PHYSICIAN J. H. Smith		14. SIGNATURE OF REGISTRAR J. H. Smith	
15. SIGNATURE OF DECEASED JAMES E. BROWN		16. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
17. SIGNATURE OF FUNERAL HOME J. H. Smith		18. SIGNATURE OF BURIAL PLACE J. H. Smith	
19. SIGNATURE OF CEMETERY J. H. Smith		20. SIGNATURE OF INTERMENT J. H. Smith	
21. SIGNATURE OF INTERMENT J. H. Smith		22. SIGNATURE OF INTERMENT J. H. Smith	
23. SIGNATURE OF INTERMENT J. H. Smith		24. SIGNATURE OF INTERMENT J. H. Smith	
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45. SIGNATURE OF INTERMENT J. H. Smith		46. SIGNATURE OF INTERMENT J. H. Smith	
47. SIGNATURE OF INTERMENT J. H. Smith		48. SIGNATURE OF INTERMENT J. H. Smith	
49. SIGNATURE OF INTERMENT J. H. Smith		50. SIGNATURE OF INTERMENT J. H. Smith	
51. SIGNATURE OF INTERMENT J. H. Smith		52. SIGNATURE OF INTERMENT J. H. Smith	
53. SIGNATURE OF INTERMENT J. H. Smith		54. SIGNATURE OF INTERMENT J. H. Smith	
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59. SIGNATURE OF INTERMENT J. H. Smith		60. SIGNATURE OF INTERMENT J. H. Smith	
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65. SIGNATURE OF INTERMENT J. H. Smith		66. SIGNATURE OF INTERMENT J. H. Smith	
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83. SIGNATURE OF INTERMENT J. H. Smith		84. SIGNATURE OF INTERMENT J. H. Smith	
85. SIGNATURE OF INTERMENT J. H. Smith		86. SIGNATURE OF INTERMENT J. H. Smith	
87. SIGNATURE OF INTERMENT J. H. Smith		88. SIGNATURE OF INTERMENT J. H. Smith	
89. SIGNATURE OF INTERMENT J. H. Smith		90. SIGNATURE OF INTERMENT J. H. Smith	
91. SIGNATURE OF INTERMENT J. H. Smith		92. SIGNATURE OF INTERMENT J. H. Smith	
93. SIGNATURE OF INTERMENT J. H. Smith		94. SIGNATURE OF INTERMENT J. H. Smith	
95. SIGNATURE OF INTERMENT J. H. Smith		96. SIGNATURE OF INTERMENT J. H. Smith	
97. SIGNATURE OF INTERMENT J. H. Smith		98. SIGNATURE OF INTERMENT J. H. Smith	
99. SIGNATURE OF INTERMENT J. H. Smith		100. SIGNATURE OF INTERMENT J. H. Smith	

RECEIVED
JUL 22 1957
BUREAU V. 2

07222

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 1929 Maisel Street			
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last MOORE				4. DATE OF DEATH Month July Day 8 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/94	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Greensburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.A.A.							
13. FATHER'S NAME Charles Moore				14. MOTHER'S MAIDEN NAME Lydia Lingie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec. Folder. Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bladder Calculus. Cystitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 28, 19 57 , to July 8 , 19 57 , and that death occurred at 7:25P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 7/8/57							
ACTUAL SIGNATURE Garfield D. Kingston M.D.				PHYSICIAN'S NAME (Type) GARFIELD D. KINGTON, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight ADDRESS Wm Cook - Blight Funeral Home, St. Paul & Preston Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 7/12/57		24b. REGISTRAR'S SIGNATURE Dr. Danvers Fisher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MEDICAL HISTORY [Illegible]		HISTORY OF PRESENT ILLNESS [Illegible]		POST-MORTEM EXAMINATION [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

BUREAU V. 2

JUL 15 1957

RECEIVED

RECEIVED

JUL 16 1957

BUREAU V. S.

TO DEP
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MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d
rificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerc
to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your
DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the

necessary, please exe
rior. Page 4 should be

rior to burial cremation

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07207

Reg. Dist. No.

44

e7224

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital			d. STREET ADDRESS 3156 WOODRING AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Canillo First MUSCELLO Middle MUSCELLO Last			4. DATE OF DEATH Month 7 Day 27 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-91	9. AGE (In years) 65 yrs.	IF UNDER 1 YEAR Months 9 Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Driller		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Torano Nuovo-Teramo-Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Dominic Muscello		
14. MOTHER'S MAIDEN NAME Rosa Di Giantomaso			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 213-07-0133			17. INFORMANT Mary Muscello (Wife) Address 3156 Woodring Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound fractured skull. Subluxation of right DUE TO ankle. Almost complete avulsion of glans penis. Conditions, if any, which gave rise to immediate cause (b) D.O.A. (c) DUE TO (c) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by an automobile on Shipyard Road, near Flange Mill			
20c. TIME OF INJURY Month, Day, Year 7:25 p.m. 7-27-1957	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B.S. Shipyard	20f. (City or town) Sparrows Point	(County) Balto	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M.B. Davis			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30 1957	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		22d. LOCATION (City, town, or county) Baltimore Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Voce			24. REC'D BY REGISTRAR JUL 29 1957		
ADDRESS 322 S. High St.			24b. REGISTRAR'S SIGNATURE Lawrence L. Farley		

MEDICAL CERTIFICATION

03

2

or removal.

(5)

MARYLAND STATE DEPARTMENT OF HEALTH - BAYVIEW 1017
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		MEDICAL HISTORY [Illegible]	
PRESENT ILLNESS [Illegible]		TREATMENT [Illegible]	
SIGNATURE OF EXAMINER [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF EXAMINATION [Illegible]		PLACE OF EXAMINATION [Illegible]	

BUREAU V. 2

JUL 30 1957

RECEIVED

07225

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>x 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8031 Highpoint Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. Peter Paul Mutchok</i>		4. DATE OF DEATH <i>July 10th 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 27, 1917</i>
9. AGE (In years last birthday) <i>39</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pennsylvania</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Mutchok</i>		14. MOTHER'S MAIDEN NAME <i>Mary (Last name unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Mary Mutchok, 8031 Highpoint Road.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Essential Hypertension</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>25 minutes</i> <i>Several years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>444x</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1955</i> to <i>July 1957</i> , that I last saw the deceased alive on <i>July 10, 1957</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William A. Harris</i> M.D.		ADDRESS (Street, city or town, state) <i>8100 Harford Road</i> DATE SIGNED <i>7/11/57</i>	
PHYSICIAN'S NAME (Type) <i>Dr. S. Elliott Harris</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/1/1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, lawn, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>7/12/57</i>	24b. REGISTRAR'S SIGNATURE <i>R. A. Bacon</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 12 1957

RECEIVED
JUL 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07209 38

07226

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6311 Mossway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Ross</u> Last <u>Myers Jr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ch. of board</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>55</u>	
13. FATHER'S NAME <u>J. Ross Myers</u>				14. MOTHER'S MAIDEN NAME <u>Emma Barnitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs. J. Ross Myers</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF BRAIN</u> DUE TO <u>162x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA OF BRAIN</u> DUE TO <u>2</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>July 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 13</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John M. Scott</u> M.D.				PHYSICIAN'S NAME (Type) <u>John M. Scott</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) <u>Pikesville Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balt</u> ADDRESS <u>17</u>				24a. REC'D BY REGISTRAR <u>7/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07210

07227

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wayne Convalescent Home</u> <u>98 Smithwood Avenue</u>		d. STREET ADDRESS <u>24 Sanford Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Wilhelmine L. Neuman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1957</u>	
S. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 7, 1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>86</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George F. Neuman, 24 Sanford Ave, Catonsville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Hemiplegic Right. Degenerative Heart Disease with Auricular Fibrillation.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334 Confusions for 4 Sculp incident to fall after stroke</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21, 1957</u> to <u>July 21, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Mc Grath</u>		DATE SIGNED <u>7/21/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. Mc Grath</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Ave. Catonsville 28 md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JUL 24 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

BUREAU V. S.

JUL 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07228

CERTIFICATE OF DEATH

0721131
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1921 Gwynn Oak Ave				d. STREET ADDRESS 1921 Gwynn Oak Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Rose A. Nolan				DATE OF DEATH Month July Day 20 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1888	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dennis Walsh		14. MOTHER'S MAIDEN NAME Ellen Byrne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Patrick J. Nolan - 1921 Gwynn Oak			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/10 , 19 57 , to 7/20 , 19 57 , that I last saw the deceased alive on 7/19 , 19 57 , and that death occurred at 6 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton Schlenker				ADDRESS (Street, city or town, state) 6411 Windsor Mill Rd. Md.			
DATE SIGNED 7/20/57							
PHYSICIAN'S NAME (Type) Milton Schlenker							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1957		22c. NAME OF CEMETERY OR CREMATORY New Cathera 1		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury				ADDRESS - 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR JUL 23 1957	
24b. REGISTRAR'S SIGNATURE Dr. M. M. Martin							

John T. Stansbury - Civil Engineer
 1915-1917 New Orleans

RECEIVED

Radio Manager William 23 1957/23

BUREAU V. S.

no — —
 Dennis Walsh
 Home Science
 female white
 Ross A. Nelson
 1251 Jackson Ave
 Woodlawn
 1301 + 0

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07212 38

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xo Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bendix Corp</i>		d. STREET ADDRESS <i>7551 Berkshire Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Le Roy Hall Nowell</i>		4. DATE OF DEATH Month Day Year <i>July 11th 19 57</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, 1913</i>
9. AGE (In years last birthday) <i>43</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Assembly Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Nowell</i>		14. MOTHER'S MAIDEN NAME <i>Elsie M. Hall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>212-03-5683</i>	
17. INFORMANT <i>Mrs. Mary E. Nowell</i>		Address <i>7551 Berkshire Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> (c) <i>Sudden</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/15/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>JUL 16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mark L. Guss</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSISSIPPI STATE DEPARTMENT OF HEALTH—BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		RELIGION		PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		PHYSICAL DATA	
LABORATORY DATA		RADIOLOGICAL DATA		PATHOLOGICAL DATA		MICROSCOPICAL DATA	
TOXICOLOGICAL DATA		ANTHROPOLOGICAL DATA		FORENSIC DATA		OTHER DATA	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION	
SIGNATURE OF WITNESS		TITLE OF WITNESS		DATE OF WITNESS		PLACE OF WITNESS	

RECEIVED
JUL 16 1957
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07230

CERTIFICATE OF DEATH

07213

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 316 N. Athol Ave. - Apt. B			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) IRENE		First E. Middle OSBOURN Last		4. DATE OF DEATH July 3,		Day 19 Year 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Blackford Osbourn				14. MOTHER'S MAIDEN NAME Charlotte Kratz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. William E. Osbourn, Jr. Address 3512 Essex Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple metastases from carcinoma of left breast DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 19 56 , to July 3, 19 57 , that I last saw the deceased alive on July 3, 19 57 , and that death occurred at 3:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 7/5/57 ACTUAL SIGNATURE George A. Knipp M.D. Baltimore 29, Maryland PHYSICIAN'S NAME (Type) George A. Knipp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt. ADDRESS Baltimore				24a. REC'D BY REGISTRAR JUL 5 '57		24b. REGISTRAR'S SIGNATURE Reed	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07231

CERTIFICATE OF DEATH

07214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. LENGTH OF STAY IN 1b <u>30 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>908 H STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE SHIPLEY OWENS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>FEW.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) yrs. <u>61</u>
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>WM. SHIPLEY</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA THORNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>G. N. CRESWELL</u>		1809 SELMA AVE <u>BALTO. 27, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT. 20</u> , 19 <u>56</u> , to <u>JULY 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JULY 15</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. MEANS</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>514 C ST. SPARROWS PT. 19, MD.</u>	
PHYSICIAN'S NAME (Type) <u>J. T. MEANS - 514 C ST. SPARROWS POINT 19, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Duke Rodley, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>18 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Lawson L. Lashley</u>

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		OCCUPATION [Faint, illegible text]		MARITAL STATUS [Faint, illegible text]		DATE OF MARRIAGE [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]		DATE OF DEATH [Faint, illegible text]	
TIME OF DEATH [Faint, illegible text]		PLACE OF INTERMENT [Faint, illegible text]		DATE OF INTERMENT [Faint, illegible text]		TIME OF INTERMENT [Faint, illegible text]	
SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF DECEASED [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF PHYSICIAN [Faint, illegible text]	
OFFICIAL USE [Faint, illegible text]		OFFICIAL USE [Faint, illegible text]		OFFICIAL USE [Faint, illegible text]		OFFICIAL USE [Faint, illegible text]	

RECEIVED
 JUL 18 1957
 BUREAU V. &

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07215

07232

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 116 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 537 Moore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle L Last PARKER				4. DATE OF DEATH Month July Day 23 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1922	
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Parker				14. MOTHER'S MAIDEN NAME Helen Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that VA attended the deceased from March 29 , 19 57 , to July 23 , 19 57 , and that death occurred at 11:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 7/24/57							
ACTUAL SIGNATURE Harold R. Johnson				PHYSICIAN'S NAME (Type) HAROLD R. JOHNSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jul 29		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead Funeral Home, 918 Druid Hill Ave.				24a. REC'D BY REGISTRAR, DATE JUL 25 1957			
ADDRESS Baltimore 1, Maryland				24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0709254

1

Jul 25 1957

RECEIVED

07233

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH <u>Rosewood State Training School</u> a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3626 Esther Place</u> <u>3Y01-4</u>			
c. LENGTH OF STAY IN 1b <u>2 years</u>				d. STREET ADDRESS <u>Baltimore, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gail</u> Middle <u>Fern</u> Last <u>Pasterfield</u>				4. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/21/54</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leroy Pasterfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary Altavater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Parents and Rosewood records</u>			
				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inspiratory Pneumonia</u> <u>344X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hydrocephalus with complicating quadriplegia</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 6,</u> 19 <u>55,</u> to <u>July 23,</u> 19 <u>57,</u> that I last saw the deceased alive on <u>July 23, 1957,</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry G. Butler</u>				ADDRESS (Street, city or town, state) <u>Owings Mills, Maryland</u>			
DATE SIGNED <u>7/24/57</u>							
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>				<u>Rosewood State Training School</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>				ADDRESS <u>3000 E. Baltimore St. Balto</u>		24a. REC'D BY REGISTRAR <u>7/24/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07217

C7234

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TOWSON CONVAL. HOME		e. STREET ADDRESS WARREN ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last CLEDA WELSH PEPPLER		4. DATE OF DEATH Month Day Year JULY 14 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31, 1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 6 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS WELSH		14. MOTHER'S MAIDEN NAME OLA PAINTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-22-5615	
17. INFORMANT EDGAR-A-PEPPLER		Address COCKEYSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arterio-sclerotic vascular disease DUE TO (c) ? yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12/57 , 19____, to 7/14/57 , 19____, that I last saw the deceased alive on 7/14/57 , 19____, and that death occurred at 4:45 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7/15/57 DATE SIGNED Edwin B. Jarrett M.D. 11 East Chase St., Baltimore-2, Md.			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Edwin B. Jarrett, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY-16/57	
22c. NAME OF CEMETERY OR CREMATORY JESSOP M.E.		22d. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. M. COOK-TOWSON, INC. TOWSON - MD.		24a. REC'D BY REGISTRAR JUL 18 1957	
24b. REGISTRAR'S SIGNATURE Robert Gray			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 3

1957 18 JUL

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0721838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 3 WKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 355 EUDOWOOD DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DARLENE M. PITTS		4. DATE OF DEATH Month JULY Day 21 Year 1957	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-57
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH HUSEN		14. MOTHER'S MAIDEN NAME ANNIE D. PITTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT —		Address —	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROCEPHALUS 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 WKS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE William A. Pillsbury M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/21/57
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY Stephenson	22d. LOCATION (City, town, or county) (State) Balto Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Chatman		24a. REC'D BY REGISTRAR JUL 25 1957	24b. REGISTRAR'S SIGNATURE Mabel Guy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07219

Reg. Dist. No.

C7236

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY in 1b 5yrlmth16dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 02502	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1 N. Meadow Rd. 165 Meadow Road	
3. NAME OF DECEASED (Type or print) FLoyd Louis Porstmann Sr.		4. DATE OF DEATH Month July Day 18 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1898
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Julius V. Porstmann		14. MOTHER'S MAIDEN NAME Nettie May Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 9227 DUE TO Conditions, if any, which gave rise to immediate cause (b) Asphyxia (c) Foreign body in bronchus (ingested food) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) shangled while sailing dunes			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year July 18 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville Baltimore Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		24a. REC'D BY REGISTRAR Jul 22 '57	
24b. REGISTRAR'S SIGNATURE Dev. Louch			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

MASSACHUSETTS DEPARTMENT OF HEALTH-BRISTOL
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

CERTIFICATE OF DEATH

07220

Reg. Dist. No. 48

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ebenezer Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clinton A. Porter</u>				4. DATE OF DEATH <u>July 29, 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30, 1877</u>	9. AGE (In years last birthday) <u>80</u> yrs.	10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William Porter</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Dorothy Porter</u>				Address <u>Ebenezer Rd, Chase, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Prostate, c</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs. -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July 25, 1957</u> , to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>July 29, 1957</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Thos E. Grossner</u> M.D. _____							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orem's Methodist</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louisa Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>JUL 31 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07238

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rheem Manufacturing Co.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2. Baltimore			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 1 6937 Conley Street			
3. NAME OF DECEASED (Type or print) First Elwood Middle Price Last Price				4. DATE OF DEATH Month July Day 18 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 1916	9. AGE (In years last birthday) 40 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper		10b. KIND OF BUSINESS OR INDUSTRY Rheem Manufacturing		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Price				14. MOTHER'S MAIDEN NAME Elsie Collett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 189-05-1649		17. INFORMANT Mrs. Dorothy Price Address 6937 Conley Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Myocardial Infarction DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 19 57 to July 18 19 57 , that I last saw the deceased alive on July 18 19 57 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John E. Gorman M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe St.				24a. REC'D BY REGISTRAR JUL 23 1957			
24b. REGISTRAR'S SIGNATURE <i>Lawson</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 23 1967

RECEIVED

07239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 30 Days				d. STREET ADDRESS 2535 Arunah Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. QUEEN				4. DATE OF DEATH Month Day Year July 3 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1923	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greaser		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William E. Queen				14. MOTHER'S MAIDEN NAME Goldie Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-22-0538		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY						INTERVAL BETWEEN ONSET AND DEATH 4 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month VA	Day 3	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from June 3, 1957 , to July 3, 1957 , XXXXXX 5:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 7/3/57							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home, 2001 Orleans, Balto. Md.				24a. REC'D BY REGISTRAR JUL 5 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARITAL STATUS
DATE OF BIRTH
PLACE OF BIRTH

BUREAU V. S.

JUL 8 1934

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07240

CERTIFICATE OF DEATH

07223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>2mths 3days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf, Maryland</u> <u>08x02</u>				d. STREET ADDRESS <u>Waldorf, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Rawlings</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Franklin</u>				14. MOTHER'S MAIDEN NAME <u>? DeVaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO <u>Gangrene left foot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.1</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April 24</u> , 19 <u>57</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>57</u> , and that death occurred at <u>12:10a</u> m, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>			DATE SIGNED <u>7-5-57</u>		
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		CATONSVILLE 28, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 8, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookfield Methodist Nch Co</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 9 '57</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>		

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07224

(7241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b 55 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2118 Lorraine Park Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle L. Last Reed				4. DATE OF DEATH Month July Day 10 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Samuel A. Reed				14. MOTHER'S MAIDEN NAME Sallie Younger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 217-01-19674			
17. INFORMANT Mrs. Eva L. Reed				Address 2118 Lorraine Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-vascular Acc. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 wk.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 6/20 , 19 57 , to 7/11 , 19 57 , that I last saw the deceased alive on 7/9 , 19 57 , and that death occurred at 10 p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton Schlenoff				ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd.			
PHYSICIAN'S NAME (Type) Milton Schlenoff MD				DATE SIGNED 7/11/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-13-1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
22d. LOCATION (City, town, or county) Baltimore				(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong				ADDRESS 307 W. North Ave.		24a. REC'D BY REGISTRAR JUL 15 1957	
24b. REGISTRAR'S SIGNATURE Dr. J. M. Martin							

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CHIEF CLERK [Faint text]	

BUREAU V. 3

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07242

CERTIFICATE OF DEATH

07225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ston Ridge Nursing Home</u>				e. STREET ADDRESS <u>5502 Pembroke ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>COYA ELIZABETH REYNOLDS</u>				4. DATE OF DEATH Month Day Year <u>July 6 1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Nathan Wymiller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth A. Warner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. James Shea</u> Address <u>5502 Pembroke ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive Gastrointestinal Hemorrhage</u> <u>542.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular lesion Cause unknown</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>246.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>722.0 Rheumatoid arthritis severe & deformed</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>July 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4605 Edmondson ave</u> DATE SIGNED <u>7/8/57</u>							
ACTUAL SIGNATURE <u>Cliff Katliff Jr</u> M.D.				PHYSICIAN'S NAME (Type) <u>CLIFF KATLIFF JR.</u> <u>4605 EDMONDSON AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Calonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight - Calonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>July 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
LOCALITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF HEALTH		U.S. GOVERNMENT PRINTING OFFICE	

BUREAU V. 2

JUL 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07226

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14 E. Overlea Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Overlea	
3. NAME OF DECEASED (Type or print) First Middle Last Gustave H. Rippert		4. DATE OF DEATH Month Day Year July 21, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pay Master		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Rippert		14. MOTHER'S MAIDEN NAME Unknown Ficken	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. # 1		16. SOCIAL SECURITY NO. 212-09-8169	
17. INFORMANT Mrs. Lois L. Rippert		Address 14 E. Overlea Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Dis. UNDERLYING CAUSE (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH approx 2 hrs. undet.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN C. HYLE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) New Orleans, La.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassohn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR JUL 23 1957		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Rippert	

STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOW		DIVORCED		RE-MARRIED		OTHER	
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		MARINE SERVICE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
CAUSE OF DEATH		MANNER OF DEATH		SITE OF DEATH		TIME OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		SIGNATURE OF WITNESS		TITLE OF WITNESS		SIGNATURE OF JURY		TITLE OF JURY		SIGNATURE OF JURY		TITLE OF JURY	

RECEIVED
BUREAU V. S.
JUL 23 1957

07227

07244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	c. LENGTH OF STAY IN 1b <u>5 1/2 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Powers Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Estel</u> Last <u>Roberts</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Charles E Francis</u>	
14. MOTHER'S MAIDEN NAME <u>Many Ann Tombit</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lawrence Roberts-Cockeysville</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>dis ease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> to <u>July</u> , <u>1957</u> , that I last saw the deceased alive on <u>July 27</u> , <u>1957</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cockeysville, Maryland</u> DATE SIGNED <u>7/31/57</u>		
ACTUAL SIGNATURE <u>Elizabeth B. Sherrill</u> M.D. <u>Cockeysville, Md.</u>		
PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill</u> <u>Cockeysville, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 3, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Providence Methodist Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>Providence, Balto. Co., Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u> ADDRESS <u>Towson, Md.</u>
24a. REC'D BY REGISTRAR DATE <u>Aug 2</u>		24b. REGISTRAR'S SIGNATURE <u>Carl</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

AUG 2 1937

RECEIVED

Providence Hospital, Providence, R.I.
Aug. 2, 1937
Tolson, Mr.

07245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1mth 28dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2842 W Clifton Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Mary</u> Middle <u>Christina</u> Last <u>Robinson</u>		4. DATE OF DEATH		Month <u>July</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1868</u>		9. AGE (In years lost birthday) yrs. <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick W. Lammers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Christina Hoffmann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerosis, generalized and severe</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 24</u> , 19 <u>57</u> , to <u>July 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>57</u> , and that death occurred at <u>3:30 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stella Wachslar</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>7-22-57</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Howard Strong</u>				ADDRESS <u>3207 W 46th AVE.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 24 57</u>	
				REGISTRAR'S SIGNATURE <u>C. W. Leach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

RECEIVED
JUL 24 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07246

CERTIFICATE OF DEATH

0722944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 44 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2618 Shirley Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ISADORE Middle JAKE (Also: ROBINSON)				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1896	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman- Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (State or foreign country) Winston Salem, N. Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Eli Robinson				14. MOTHER'S MAIDEN NAME Jennie MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF BRONCHUS OF UPPER LOBE OF 162X SMOKE RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3 , 19 57 , to July 17 , 19 57 . XXXXXXXXXXXXXXXXXXXX and that death occurred at 10:28 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 7/17/57							
ACTUAL SIGNATURE Irving Freeman				M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 7/17/57			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-57		22c. NAME OF CEMETERY OR CREMATORY Oak Shalom		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Place, Baltimore, Md.				24a. REC'D BY REGISTRAR JUL 19 1957			
				24b. REGISTRAR'S SIGNATURE Lawson L. Parker			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07247

CERTIFICATE OF DEATH

0723038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 West Joppa Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SISTER MARY RODRIGUEZ (Catherine Gillespie)				4. DATE OF DEATH Month July Day 15 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 1876	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun				10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Ballinascreen, Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Gillespie			
14. MOTHER'S MAIDEN NAME Eliza Barnett				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Convent Records, 1001 W. Joppa Road, Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Renal DUE TO Vascular Disease (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332x						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 7 1947 to July 15 1957 , that I last saw the deceased alive on July 10 1957 , and that death occurred at 4:00 PM , from the cause and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Road			
DATE SIGNED 7/16/57				PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery	
22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.				23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lamm			
ADDRESS 4611 Pk. Hgts. Balto. Md.				24. READ BY REGISTRAR Jul 18 1957		24b. REGISTRAR'S SIGNATURE Michael Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

072318

07248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3101.4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) ARMACOST NURSING HOME REGESTER AVE		d. STREET ADDRESS 4305 MARBLE HALL ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HENRY A ROHMER		4. DATE OF DEATH Month Day Year JULY 21, 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1900
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALEMAN		10b. KIND OF BUSINESS OR INDUSTRY LIQUOR	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER A ROHMER		14. MOTHER'S MAIDEN NAME BABETTE LEDERER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. DOROTHY E ROHMER		Address 4305 Marble Hall Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 9 YRS.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-20- 19 50 to July 21, 1957 that I last saw the deceased alive on July 20, 1957 and that death occurred at 1 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Arthur Karfagin M.D. 1532 Hawthornwood Rd. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) ARTHUR KARFAGIN 1532 HAYENWOOD RD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/1957	22c. NAME OF CEMETERY OR CREMATORY Moreland Park	22d. LOCATION (City, town, or county) (State) Balto Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Inc. 127 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 23 1957 24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-12

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

CIRRHOSIS OF LIVER

Form with fields for Place of Birth, Date of Birth, Date of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 1

JUL 24 1957

RECEIVED

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07249

CERTIFICATE OF DEATH

Reg. Dist. No.

07332

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7834 Wendover Ave</u>				d. STREET ADDRESS <u>1 7834 Wendover Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Alessandro</u> Middle <u>Rosellini</u> Last <u>Rosellini</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
13. FATHER'S NAME <u>Nicola Rosellini</u>				14. MOTHER'S MAIDEN NAME <u>Zelinda Gabani</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-07-7876</u>			
17. INFORMANT <u>Mrs. Josephine Rosellini</u>				Address <u>7834 Wendover Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach with</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized metastasis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>19 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 15, 1956</u> to <u>July 29, 1957</u> , that I last saw the deceased alive on <u>7/23</u> , 19 <u>57</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan Janney</u> M.D. <u>7101 Harford Rd.</u>				ADDRESS (Street, city or town, state) <u>Baltimore 14, Md.</u>			
DATE SIGNED <u>7/30/57</u>							
PHYSICIAN'S NAME (Type) <u>Nathan Janney</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc.</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>JUL 31 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED	
EDUCATION		OCCUPATION		HABIT		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		RELIGION	
EDUCATION		OCCUPATION		HABIT		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	

BUREAU V. 3

JUL 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07250

CERTIFICATE OF DEATH

07233

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) g. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb Nursing Home - 4105 Essex Rd.				d. STREET ADDRESS 732 Milford Mill Rd.			
3. NAME OF DECEASED (Type or print) First CATHERINE Middle AUGUSTA Last ROWLES				4. DATE OF DEATH Month July Day 20 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1887	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Julius F. Scriba				14. MOTHER'S MAIDEN NAME Mary R. Douglass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mr. Charles D. Rowles - 732 Milford Mill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 X Diabetes Mellitus, abscess buttock							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 9, 1949 , to July 18, 1957 , that I last saw the deceased alive on 18 July, 19 57 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1632 Reis Rd., Pikesville 8, Md. DATE SIGNED 22 July							
ACTUAL SIGNATURE Charles H. Williams July 20, 1957				PHYSICIAN'S NAME (Type) Charles H. Williams, M.D., 1632 Reisterstown Rd., 8, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) no		22b. DATE THEREOF 7/22/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Baltore				24a. REC'D BY REGISTRAR DATE 7/23/57		24b. REGISTRAR'S SIGNATURE Dr. Wm. J. Martin	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
Medical examiner, Dr. DD Caples advised Dr. Williams to sign. Patient was seen by Dr. Paul Royse on July 20, day of death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION		EDUCATION		RELIGION		BIRTH		DEATH		BURIAL	
John A. Smith		45		Male		White		Married		Teacher		High School		Roman Catholic		1912		1957		St. Mary's	
Cause of Death		Date of Death		Place of Death		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
Heart Disease		July 24, 1957		Home		Dr. J. H. Jones		St. Mary's		Natural		J. H. Jones		[Signature]		July 24, 1957		[Signature]		July 24, 1957	
Previous Illnesses		Date of Onset		Place of Onset		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
Hypertension		June 1, 1957		Home		Dr. J. H. Jones		St. Mary's		Natural		J. H. Jones		[Signature]		June 1, 1957		[Signature]		June 1, 1957	
Family History		Date of Onset		Place of Onset		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
None		None		None		None		None		None		None		None		None		None		None	
Social History		Date of Onset		Place of Onset		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
None		None		None		None		None		None		None		None		None		None		None	
Autopsy		Date of Onset		Place of Onset		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
None		None		None		None		None		None		None		None		None		None		None	
Remarks		Date of Onset		Place of Onset		Physician		Hospital		Manner of Death		Certified by		Signature		Date		Signature		Date	
None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

JUL 24 1957

RECEIVED

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS.

07234

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1. PLACE OF DEATH o. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Fort Howard		c. LENGTH OF STAY IN lb		30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Veterans Administration Hospital		d. STREET ADDRESS		119 W. Saratoga Street		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
ARCHIE		D.		RULE		July		14		19 57	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/7/97		59 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Pressman		Publishing House		Virginia		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
William P. Rule		Martha Fielder									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes		WWI		237-14-5270		Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH		FEW MINUTES					
420.1		DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		3 YEARS					
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		422.1		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour o. m. p. m.		While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>									
21. I certify that		21a. Attended the deceased from June 14, 19 57, to July 14, 19 57.		21b. That death occurred at 10:00 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE		IRVING FREEDMAN		M.D. Veterans Administration Hospital		7/15/57					
PHYSICIAN'S NAME (Type)		IRVING FREEDMAN, M.D. Chief, Medical Port Howard, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)			
Removal		7-15-57		Oakdale Cemetery		Mt. Airy, N. Carolina					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Wm. Cook-Blight, Inc.		6009 Harford Rd., Baltimore 14		DATE 7/18/57		Dawson L. Parker					

Shipped to: Moody Funeral Home, Franklin Street, Mt. Airy, N.C. Md.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Race, Birth Date, Birth Place, Death Date, Death Place, Cause of Death, and other details. The text is mostly illegible due to the quality of the scan.

BUREAU V. 3

JUL 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07235

07252

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Forge		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 Branden Road		d. STREET ADDRESS 107 Branden Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Miller Samuels		4. DATE OF DEATH July 5, 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1913
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME H. Sinclair Miller		14. MOTHER'S MAIDEN NAME Anne Ruwart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John B. Miller		Address 7222 Linark Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis from DUE TO (c) Carcinoma of colon 5 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1947 to July 5, 1957 , that I last saw the deceased alive on 7-5-1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas Edgar Russell Jr., M.D.		ADDRESS (Street, city or town, state) 3901 N. Charles St.	
PHYSICIAN'S NAME (Type) Thomas Edgar Russell Jr., M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Pl.	
24a. REC'D BY REGISTRAR JUL 10 1957		24b. REGISTRAR'S SIGNATURE Mark Guy	

• 2011 •

[illegible]

BUREAU V. S.

JUL 10 1957

RECEIVED

07130

CERTIFICATE OF DEATH

Reg. Dist. No.

41

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b <u>53 Dundalk 22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>7147 Holabird Avenue</u>				d. STREET ADDRESS <u>7147 Holabird Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Percy</u> Last <u>Samuels</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25, 1898</u>	
9. AGE (In years lost birthday) yrs. <u>58</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Burner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown, Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Samuels</u>				14. MOTHER'S MAIDEN NAME <u>Anne Leichen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>232-20-2214</u>		17. INFORMANT <u>William H. Samuels, 6102 Fortview Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>17 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 July</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B.W. Sollod</u> M.D. <u>2908 DUNRAN RD</u> DATE SIGNED <u>7-19-57</u>							
PHYSICIAN'S NAME (Type) <u>B.W. SOLLOD, M.D.</u> <u>Dundalk - 22 - Inf</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>ML 221957</u>		24b. REGISTRAR'S SIGNATURE <u>Thm. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07237

07253

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7801 Oak Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Eva Estelle Schafer</u>				4. DATE OF DEATH Month Day Year <u>July 7th 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 8, 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>triez Instruments</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Pool</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Henry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Harry J. Schafer, Sr. 7801 Oak Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of St. ovary</u> <u>175X</u> DUE TO <u>with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>July 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>57</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nichols Harris</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8100 Harford Road #14 7/8/57</u>			
M.D. <u>S. Elliott Harris</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 10 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Bacon</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALABAMA	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. EDUCATION High School		12. RELIGION None		13. SOCIAL SECURITY NUMBER 1-345-67890		14. MOTHER'S MAIDEN NAME None		15. FATHER'S NAME None	
16. DATE OF DEATH 6-4-68		17. PLACE OF DEATH MEMPHIS, TENNESSEE		18. CAUSE OF DEATH Assault		19. MANNER OF DEATH Homicide		20. MEDICAL EXAMINER'S NAME None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF NEXT OF KIN None		23. SIGNATURE OF MEDICAL EXAMINER None		24. SIGNATURE OF CORONER None		25. SIGNATURE OF REGISTRAR None	

BUREAU V. 5

JUL 10 1967

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07131

CERTIFICATE OF DEATH

0723841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 S. Dundalk Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROSINE SCHLAITL			4. DATE OF DEATH Month July Day 16 Year 1957				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1872		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Ludwig Friz				14. MOTHER'S MAIDEN NAME Fredericka ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Bertha Golly 60 S. Dundalk Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1948 , to 16 July , 19 57 , that I last saw the deceased alive on 14 July , 19 57 , and that death occurred at U.P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE B.W. SOLLID			ADDRESS (Street, city or town, state) 2900 Dunstan Rd			DATE SIGNED 7-18-57	
PHYSICIAN'S NAME (Type) B.W. SOLLID, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				24a. REC'D BY REGISTRAR DATE 19 1957		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

MARYLAND STATE DEPARTMENT OF HEALTH-JACKSONVILLE, FL

07254 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) HOWARD SCHEFF		2. DATE OF DEATH 7-10-57	
3. PLACE OF DEATH: Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 10705 Stoneleigh RD, Baltimore		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) STONELEIGH-Baltimore 12	
D. STREET ADDRESS (If rural, give location) 705 STONELEIGH RD.		E. LENGTH OF STAY IN BALTIMORE life	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH July 8, 1897.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Building Contractor	9. AGE (in years, last birthday) 60
11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Scheff		14. MOTHER'S MAIDEN NAME Barbara Kahl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes - 1918 - Army		16. SOCIAL SECURITY NO. 216-01-3432	
17. INFORMANT Ms. Josephine Scheff, same		ADDRESS	
18. 420.1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Thrombosis, recurrent	
ANTECEDENT CAUSES		(B) Arteriosclerotic cardiovascular disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) Small 1938	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY July 1957		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? ---		22. I certify that (I) (this hospital) attended the deceased from July 1957 to July 8 1957 , that (I) (we) last saw the deceased alive on July 8 1957 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.	
23A. SIGNATURE Robert E. Enzor		23B. ADDRESS 79 Maryland Ave. Towson, MD	
23C. DATE SIGNED 7-10-57		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7-13-57		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem	
24D. LOCATION (City, town, or county) Baltimore		(State) MD	
DATE RECEIVED BY LOCAL REGISTRAR 7/12/57		REGISTRAR'S SIGNATURE Mable C. Gray	
25. FUNERAL DIRECTOR Leonard J. Kuck		ADDRESS 5305 Harford	

VS. REGISTRAR

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WAXEN BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED IN BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

BUREAU V. S.

JUL 16 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07255

CERTIFICATE OF DEATH

07240

Reg. Dist. No. 40

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COVENTON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COVENTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AFFELD AVE</u>		STREET ADDRESS (If rural give location) <u>AFFELD AVE</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Lewis</u> (Middle) <u>Schultz</u> (Last)		(Month) <u>July</u> (Day) <u>25</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 22, 1915</u>
		9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ANTONE SCHULTZ</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-05-0504</u>	
		17. INFORMANT & ADDRESS <u>HARRY SCHULTZ 3008 ROYSTON AVE.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
422-1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart Failure</u>			
19a. DATE OF OPERATION <u>434-1</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 23, 1957</u> to <u>July 25, 1957</u> , that I last saw the deceased alive on <u>July 23, 1957</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city, town, state) <u>Kingville Md.</u> DATE SIGNED <u>7-25-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>7-27-57</u>	NAME OF CEMETERY OR CREMATORY <u>FORK METHODIST CHURCH</u>	LOCATION (City, town, or county) (State) <u>MARYLAND</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Dr. Walter Thompson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Bright</u>	ADDRESS <u>6009 Harford Rd.</u>
DATE <u>7/29/57</u>			

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07248
38

07256

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Rodgers Forge Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>240 Rodgers Forge Rd.</u>				d. STREET ADDRESS <u>1240 Rodgers Forge Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>JOSEPH</u> Last <u>SHAMBERGER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 20, 1896</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing Business</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Daniel Shamberger</u>				14. MOTHER'S MAIDEN NAME <u>Martha J.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mr. C. Edwin Fitzell - 3342 Gilman Terrace</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>10 yrs</u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/5/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>				22d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u> (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Baltimore</u>				24a. REG'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

7/3/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07243

07257

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Catonsville</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>29yr5mth14dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>			d. STREET ADDRESS <u>Baltimore City Hospital (NR)</u>		
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Sheckells</u> Last <u>Sheckells</u>			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>19 57</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles R. Sheckells</u>			14. MOTHER'S MAIDEN NAME <u>Jane Minnifree</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture of skull</u> <u>900.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>due to a fall</u> (c) <u>accident</u> caused lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. was pushed by another patient causing her to fall down steps with resulting injury of head.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>7-23-57</u> Hour <u>6:20</u> o. m. <u>200K</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>	
20f. (City or town) <u>Catonsville 28, Md.</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>George M. Kieffer</u>		M.D. <u>George M. Kieffer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING GROVE STATE HOSP.</u>	
22d. LOCATION (City, town, or county) <u>Catonsville 28, Md.</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>SPRING GROVE STATE HOSPITAL</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 6 '57</u>		
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			DATE <u>July 23, 57</u>		

Query to Barb C.H. re: "no record" 8/13/57 - s.

BUREAU V. 3

UG 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07258

CERTIFICATE OF DEATH

Item 2 Film G218 8-1-57 et

Reg. Dist. No.

07244

30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Catonsville</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>76 Fidelity Avenue House in the Park</u>		STREET ADDRESS <u>Altamont Hotel</u> (If rural, give location) <u>Putaw Place & ...</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Solomon</u> (Middle) <u>Shester</u> (Last) <u>Shester</u>	4. DATE OF DEATH	(Month) <u>July</u> (Day) <u>25</u> (Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1901</u>
9. AGE last birthday <u>55</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Mfn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salisman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rate Samuel Shester</u>		14. MOTHER'S MAIDEN NAME <u>Lena Stetsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>William Applefield - 3805 Helton Rd</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1538 Immediate cause (a) Carcinoma of Large Bowel

Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH 2nd

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>June 1957</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma bowel with metastases</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 18, 1957, to July 25, 1957, that I last saw the deceased alive on July 25, 1957, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE Henry D. Rosenthal, M.D. (Degree or title) ADDRESS 5833 Park Hts Ave DATE SIGNED 7-25-57

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>July 26/57</u>	NAME OF CEMETERY OR CREMATORY <u>Beth Yeshel</u>	LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>
DATE REC'D BY LOCAL REG <u>7/26/57</u>	REGISTRAR'S SIGNATURE <u>A. G. Hedrick</u>	24. FUNERAL DIRECTOR <u>Samuel ...</u>	ADDRESS <u>1124-26 W. North Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07245

Reg. Dist. No.

43

07259

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULLERTON</u>				c. LENGTH OF STAY IN 1b <u>PARKVILLE X2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>8506 OAKLEIGH RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WARREN</u> Middle <u>A</u> Last <u>SHOOK</u>				4. DATE OF DEATH Month <u>7</u> Day <u>-27</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 27 1931</u> <u>26</u> yrs.	
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIVEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ALBERT H. SHOOK</u>				14. MOTHER'S MAIDEN NAME <u>VELMA CLEAVER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MARLENE SHOOK</u> Address <u>8506 OAKLEIGH</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE GUNSHOT WOUNDS OF</u> <u>981X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HEAD</u> (c), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SILVER SPRING ROAD</u>			
20c. TIME OF INJURY Month, Day, Year <u>9</u> Hour <u>15</u> a. m. <u>7-27</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CAR-Street</u>		20f. (City or town) (County) (State) <u>BALTIMORE MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R S Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R S FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JULY 30 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u>				23b. ADDRESS <u>4216 BELAIR</u>		24a. REC'D BY REGISTRAR <u> </u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. R. L. Reardon</u>		DATE <u>30 1957</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

JUL 30 1957

RECEIVED

7-3-105 064X02

07132 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY

BALTO

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

BALTO - 22

LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

BALTO

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

BALTO 22 - MD

HOSPITAL OR INSTITUTION OR STREET ADDRESS

STREET ADDRESS (If rural give location)

2110 OAKLAND AVE Balto

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

FRANK J. SLOWIK Jr.

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

July 10 1957

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MALE WHITE

MARRIED Jan 30 1887

70 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

RETIRED PUMPING ST. BALTO. CITY

BALTO MD.

U.S.A

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

MICHAEL SLOWIK

JOSEPHINE STREGOLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

BERTHA A. SLOWIK 2110 OAKLAND AVE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebro Vascular accident

Interval Between Onset and Death

Sudden

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

DUE TO

Arteriosclerotic Cardio Vascular disease

5 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1957, to July 10, 1957, that I last saw the deceased

alive on July 10, 1957, and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7/12/57 Wm. M. Kelly, Jr.

Marie Sialkowski 1000 S. Kenwood Ave

Balto. 24 - Md.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 15 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07260

CERTIFICATE OF DEATH

07247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balt. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebhrille		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hebhrille		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) 3110 Rolling Road				d. STREET ADDRESS 3110 Rolling Rd.			
3. NAME OF DECEASED (Type or print) First Ida Middle G Last Smith				4. DATE OF DEATH Month July Day 17 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Ness				14. MOTHER'S MAIDEN NAME Lucy Gibson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. John C. Smith - Dorsey, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) dehydration - delirium DUE TO malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) — DUE TO — (c) —						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15 , 19 57 , to July 17 , 19 57 , that I last saw the deceased alive on July 17 , 19 57 , and that death occurred at 30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. Casellaro M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stensbury ADDRESS 6411 Windsor M. Rd.				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Dr. M. A. Martin	

new school

UL 22 1957

BUREAU V. S.

no	—	—	Mr. John C. Smith - Dec 22, 1897	Mr. John C. Smith - Dec 22, 1897
William C. West	—	—	Lucy Gibson	Lucy Gibson
scientific	—	—	—	—
female white	✓	✓	July 23, 1897	July 23, 1897
I do	Q	Q	Smith	Smith
3100 Rolling Road	3100 Rolling Road	3100 Rolling Road	3100 Rolling Road	3100 Rolling Road
Heppville	Heppville	Heppville	Heppville	Heppville
Ex 140	Ex 140	Ex 140	Ex 140	Ex 140

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07261

07248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) MARIE H. SMITH		2. DATE OF DEATH JULY 15, 1957	
3. A. BALTIMORE CITY, MARYLAND Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City	
B. FULL NAME OF (If not in hospital or institution, give street address or location) RIDGEWAY MANOR FOR AGED.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City.	
D. STREET ADDRESS (If rural, give location) 707 North Port St. (5).			
c. Length of stay in Baltimore LIFE			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 29, 1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 59
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Schroeder		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harold D. Smith		ADDRESS 7603 Maple Road Dundalk 22, Md.	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 541.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 331x		(A) Atherosclerosis Cardio (B) Diabetes Mellitus (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I, PART II		19A. DATE OF OPERATION	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from April 12, 1953 to July 15, 1957 , that (I) (we) last saw the deceased alive on July 15, 1957 , and that death occurred at 12:55 A.M. , from the causes and of the date stated above.			
23A. SIGNATURE Wm. R. Meyer		23B. ADDRESS 156 N. Melton Ave	
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		23C. DATE SIGNED July 15, 1957	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/18/57	
24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1957		25. FUNERAL DIRECTOR H. M. M. Miller	
REGISTRAR'S SIGNATURE H. M. M. Miller		ADDRESS 2334 Gellerson St.	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and log THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



1957 22 JUL

RECEIVED

07262

CERTIFICATE OF DEATH

07249

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 20yr6mth4dys		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 824 Park Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Naomi Middle Todd Last Smith		4. DATE OF DEATH Month July Day 24 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathan W. Todd		14. MOTHER'S MAIDEN NAME Mary Bozman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 22 , 19 57 , to July 24 , 19 57 , that I last saw the deceased alive on July 24 , 19 57 , and that death occurred at 4:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 7-24-57			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		July 27, 1957	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cape Charles Cem.		Cape Charles Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.V. Singleton, Glen Burnie		24a. REC'D BY REGISTRAR 29 57	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
07263
CERTIFICATE OF DEATH

07250

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD VA.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gwyn Oak.</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOPEWELL VA. 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AUGSBURG HOME</u>				d. STREET ADDRESS <u>709 E. Poythress St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH ANN SMITH.</u>				4. DATE OF DEATH Month Day Year <u>JULY 5 19 57</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD. PA.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>CHAS MCKENNA.</u>				14. MOTHER'S MAIDEN NAME <u>? KNEPP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>RECORDS AUGSBURG HOME</u>			
17. INFORMANT <u>CAMPFIELD Rd</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 3 -</u> , 19 <u>55</u> , to <u>July 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 2 -</u> , 19 <u>57</u> , and that death occurred at <u>10:27 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul L. Chamberlain</u> M.D. <u>4108 Liberty St Baltimore Md.</u> PHYSICIAN'S NAME (Type) <u>4-6-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/1 1957</u>		<u>ST. PAUL'S VIOLETTVILLE</u>		<u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Blumaine</u>				ADDRESS <u>6067 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 9 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Hm. Masterson</u>							

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED John Doe		DATE OF DEATH July 15, 1957	
PLACE OF DEATH Home		AGE 45	
SEX Male		RACE White	
BIRTH DATE March 10, 1912		BIRTH PLACE Baltimore, Md.	
MARRIAGE DATE June 1, 1935		MARRIAGE PLACE Baltimore, Md.	
NAME OF SPOUSE Jane Doe		OCCUPATION Teacher	
EDUCATION High School		RELIGION Catholic	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF REGISTRAR John Doe	
DATE OF SIGNATURE July 15, 1957		DATE OF SIGNATURE July 15, 1957	

RECEIVED

JUL 15 1957

BUREAU V. S.

07265

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto MD</u> ✓			
c. LENGTH OF STAY IN 1b <u>10 yrs</u>				3. VOI-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chesbury Home</u>				d. STREET ADDRESS <u>721 Sudhurst St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary E.</u> Middle <u>Spillman</u> Last <u>Spillman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 16, 1870</u> AGE (In years, last birthday) <u>87</u> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Balto Geo.</u>			
13. FATHER'S NAME <u>John Zaiser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Records Home 6811 Campfield</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (Recurrent)</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- Arterio Sclerotic Heart Disease</u> (c) <u>- Generalized Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>4 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 1 -</u> , 19 <u>53</u> , to <u>July 29 -</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 25 -</u> , 19 <u>57</u> , and that death occurred at <u>5:58 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u>				ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto. Md.</u> DATE SIGNED <u>7-29-57</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers M.D.</u>				ADDRESS <u>4108 Liberty Hts. Balto. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 1, 57</u>		<u>Baltimore Cem</u>		<u>Balto MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul A. Newman</u>				ADDRESS <u>6067 Hanford Rd</u>		24a. REC'D BY REGISTRAR <u>Aug 5 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. H. M. Martin</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07266

CERTIFICATE OF DEATH

07253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 12yrl0mth24dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 724 S. Ann Street			
3. NAME OF DECEASED (Type or print) First Mary Middle Stanislaw Last S				4. DATE OF DEATH Month July Day 5 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY Parochial school		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Jacob Skrzyniecki				14. MOTHER'S MAIDEN NAME Frances Golembiewska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary emboli 422.1 DUE TO (b) Myocardial degeneration + failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170x Carcinoma of rt breast							INTERVAL BETWEEN ONSET AND DEATH unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 26, 19 56 to July 5 19 57 , that I last saw the deceased alive on July 4 19 57 , and that death occurred at 5:40 AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7.5.57							
ACTUAL SIGNATURE Gertrude J. Fleischmann M.D.				PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-8-57		22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS		22d. LOCATION (City, town, or county) (State) 1300 DUNDALK AVE	
23. FUNERAL DIRECTOR'S SIGNATURE George G. Weber ADDRESS 703 S. Ann St				24a. REC'D BY REGISTRAR DATE 7-9-57		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

BUREAU V. S.

JUL 9 1957

RECEIVED

07267

CERTIFICATE OF DEATH

07254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyrlmthlldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 22 Sanders Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. List Last Sterner		4. DATE OF DEATH Month July Day 5 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1899
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Frederick List		14. MOTHER'S MAIDEN NAME Jinnier Gerlach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary occlusion DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15 , 19 57 , to July 5 , 19 57 , that I last saw the deceased alive on July 5 , 19 57 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-5-57	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner		24a. REC'D BY REGISTRAR Wm. J. Tichner DATE	
ADDRESS Home North & Pa Aves		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07268

CERTIFICATE OF DEATH

07255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 1 MONTH 20 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Masonic Home				d. STREET ADDRESS 2915 KESWICK ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EDITH ELLSWORTH STONE				4. DATE OF DEATH Month Day Year JULY 20 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1-1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME CHARLES E. BURRIER				14. MOTHER'S MAIDEN NAME ANNA M. McCULLOUGH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-03-47698		17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompression due to 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardiac DUE TO Vascular Disease (c)							INTERVAL BETWEEN ONSET AND DEATH over 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTO MD				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 5/27 , 19 57 , to 7/19 , 19 57 , that I last saw the deceased alive on 7/19/57 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter J. Kuo				ADDRESS (Street, city or town, state) Cockeysville, Md.			
DATE SIGNED 7/19/57							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-23-57		Druid Ridge		BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Inc				ADDRESS 12175X PAUL SX		24a. REC'D BY REGISTRAR DATE 8-24-57	
24b. REGISTRAR'S SIGNATURE Paul							

BUREAU V. S.

JUL 24 1957

RECEIVED

07269

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6708 Beech Ave.				d. STREET ADDRESS 6708 Beech Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Franz Middle L. Last Struhs				4. DATE OF DEATH Month July Day 28 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1880	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 28 Hours 15 Min. 7		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silversmith-Retired				10b. KIND OF BUSINESS OR INDUSTRY Silversmith			
13. FATHER'S NAME John Struhs				14. MOTHER'S MAIDEN NAME Wilhelmina Wallring			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-2912		17. INFORMANT Address Mrs. Catherine Struhs 6708 Beech Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 177X DUE TO (b) metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) prostatic cancer INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 16, 1957 to July 28, 1957 , that I last saw the deceased alive on July 28, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. D. RIGLER				DATE SIGNED 1W OVERLEA AVE			
PHYSICIAN'S NAME (Type) J. D. RIGLER				BALTO 6, MD 7-30-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cassidy Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR JUL 31 1957	
				24b. REGISTRAR'S SIGNATURE Mal. L. Reynolds			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

07270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO, 28				c. LENGTH OF STAY IN 1b 19yr7mthldy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE ST. HOSP.				e. STREET ADDRESS Hamburger Avenue			
3. NAME OF DECEASED (Type or print) GLADYS First Middle Last				4. DATE OF DEATH 7 Month 7 Day 1957 Year			
5. SEX FEM		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-24-1898	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IOWA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS L. NANCE			
14. MOTHER'S MAIDEN NAME ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT BUY STURTZ HUSBAND Address UNKNOWN			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary occluding (c) Arteriosclerotic + hypertensive cardiovascular disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 449X							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 7-7-57 , 19 57 , to 7-7- , 19 57 , that I last saw the deceased alive on 7-7- , 19 57 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslor				DATE SIGNED 7-9-57			
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.				ADDRESS (Street, city or town, state) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY Cris. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE JUL 10 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES E. HARRIS		JULY 11 1957	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		PLACE OF BIRTH	
Retired		Maryland	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		PLACE OF DEATH	
Coronary Artery Disease		Home	
TIME OF DEATH		SIGNATURE OF PHYSICIAN	
10:30 AM		J. E. HARRIS	
PLACE OF DEATH		SIGNATURE OF REGISTRAR	
Home		J. E. HARRIS	
DATE OF DEATH		DATE OF REGISTRATION	
JULY 11 1957		JULY 11 1957	

RECEIVED
JUL 11 1957
BUREAU V. 1

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armecost Nursing Home		d. STREET ADDRESS 1504 Marble Hall Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAMIE Middle H. Last SWEARER		4. DATE OF DEATH Month July Day 14 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1877 9. AGE (In years lost birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store 11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Charles Swearer		14. MOTHER'S MAIDEN NAME Cornelia Owen Tomlinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Raymond R. Rever Address Annapolis, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident		INTERVAL BETWEEN ONSET AND DEATH 7/1/57	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 451X Worker		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to 7/1/57 , 19____, that I last saw the deceased alive on 7/1/57 , 19____, and that death occurred at 9:24 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE WATER E. KARFGIN M.D.		ADDRESS (Street, city or town, state) 4331 Harbor Rd DATE SIGNED 7/16/57	
PHYSICIAN'S NAME (Type) WATER E. KARFGIN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/17/57	22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto.		24a. REG'D BY REGISTRAR JUL 18 1957 24b. REGISTRAR'S SIGNATURE Mark Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

HUSBAND

WIFE

CHILD

OTHER

OTHER

OTHER

OTHER

OTHER

OTHER

OTHER

OTHER

BUREAU V. 3

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07259

07135

CERTIFICATE OF DEATH

Reg. Dist. No.

4v

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. LENGTH OF STAY IN 1b <u>48 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hedge Avenue</u>				d. STREET ADDRESS <u>1 Ridge Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPHINE</u> First Middle Last				4. DATE OF DEATH <u>July 5 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12 - 1891</u> 86 yrs.	
9. AGE (In years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
13. FATHER'S NAME <u>STRUNG</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>420.1</u>		17. INFORMANT <u>Fredrick U. Beiler</u> Address <u>1014 Francis Ave - Balto 27 Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute coronary - probably subacute</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension sim - a coronary syndrome</u> DUE TO <u>Diabetes mellitus</u> (c) <u>5 months</u> <u>5 or 6 weeks</u> <u>+ years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> <u>Overweight</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>✓</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) <u>✓</u> (County) (State)		21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>57</u> , to <u>July 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 5</u> , 19 <u>57</u> , and that death occurred at <u>AP</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fredrick U. Beiler</u>		M.D. <u>1014 Francis Ave - Balto 27 Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>FREDERICK U. BEILER</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Blvd. Md.</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick U. Beiler</u>		ADDRESS <u>1014 Francis Ave - Balto 27 Md.</u>		24a. REC'D BY REGISTRAR <u>9 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Kuffner</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. DATE OF BIRTH</p> <p>4. PLACE OF BIRTH</p>		<p>5. MARITAL STATUS</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p>	
<p>8. PLACE OF DEATH</p> <p>9. DATE OF DEATH</p> <p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p> <p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF DECEASED</p> <p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF DECEASED</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF DECEASED</p> <p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p> <p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF DECEASED</p> <p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p> <p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF DECEASED</p> <p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>		<p>31. SIGNATURE OF DECEASED</p> <p>32. SIGNATURE OF DECEASED</p>	
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<p>53. SIGNATURE OF DECEASED</p> <p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF DECEASED</p> <p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p> <p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF DECEASED</p> <p>60. SIGNATURE OF DECEASED</p>	
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<p>73. SIGNATURE OF DECEASED</p> <p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF DECEASED</p> <p>76. SIGNATURE OF DECEASED</p>	
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<p>81. SIGNATURE OF DECEASED</p> <p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF DECEASED</p> <p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p> <p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF DECEASED</p> <p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p> <p>90. SIGNATURE OF DECEASED</p>		<p>91. SIGNATURE OF DECEASED</p> <p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p> <p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF DECEASED</p> <p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p> <p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF DECEASED</p> <p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. 3

JUL 9 1957

RECEIVED

07272

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN TB 33 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 1041 West Lanvale Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SQUIRE M. TAYLOR				4. DATE OF DEATH July Month Day Year 30 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1887	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min. 70		IF UNDER 24 HRS. Months Days Hours Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Rocky Mount, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Wesley Taylor				14. MOTHER'S MAIDEN NAME Mary S. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-16-7891		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> attended the deceased from June 27 , 19 57 , to July 30 , 19 57 . JUNE 27 and that death occurred at 8:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 7/30/57 ACTUAL SIGNATURE <i>Chien Wei Lan</i> M.D. VAH, FORT HOWARD, MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> Charles R. Law Mortuary, 802-04 Madison Ave. Baltimore 1, Maryland				24a. REC'D BY REGISTRAR DATE Aug 2-57		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Forbes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(Faint bleed-through from the reverse side of the page)

BUREAU V. S.

AUG 5 1957

RECEIVED

07273

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Baltimore, Maryland	
c. LENGTH OF STAY IN 1b 2mths10dys		d. STREET ADDRESS 909 Elm Ridge Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Emilia Last Thom		4. DATE OF DEATH Month July Day 28 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1874
9. AGE (in years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 7 Days 28	11. IF UNDER 24 HRS. Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓	
13. FATHER'S NAME August Thom		14. MOTHER'S MAIDEN NAME Augusta Mielke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardiac failure 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) cardiovascular disease (c) fracture left femur DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 accident		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While walking on ward, pt. fell to floor, sustaining fractured left femur	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:45 7-9 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 28, 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-57	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE James J. [illegible]		24a. REC'D BY REGISTRAR 4107 [illegible]	
24b. REGISTRAR'S SIGNATURE Q. L. [illegible]		DATE JUL 31 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOT STATE
LOCAL DIST

RECEIVED
JUL 31 1957

INVESTIGATIVE DIVISION
DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 31 1957
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07262

07274

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millers, Rural</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beckleysville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>M.</u> Last <u>Tracey</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>Dec. 4, 1893</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Irvin McCullough</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>183-188-133A</u>	
17. INFORMANT <u>James W. Tracey, Millers, Md.</u>		Address <u>Millers, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ch. Valvula (Aortic Disease)</u> DUE TO (c) <u>(Aortic)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> m. <u>30</u> m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1957</u> to <u>July 18, 1957</u> , that I last saw the deceased alive on <u>July 18, 1957</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>New Sweden, Pa.</u>	
ACTUAL SIGNATURE <u>J. H. Bowers</u> M.D.		DATE SIGNED <u>7/17/57</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Bowers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Parkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>7/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Gaulton</u>	

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07263

Reg. Dist. No. 35

07275

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> c. LENGTH OF STAY IN 1b <u>37yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Meredith Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> X! d. STREET ADDRESS <u>Meredith Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STella</u> First <u>AGnes</u> Middle <u>TROUT</u> Last		4. DATE OF DEATH <u>July 3</u> Month <u>1957</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16 1899</u> <u>37</u> yrs.
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Waltemyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Shetter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>11-38-10000</u>	
17. INFORMANT <u>Maurice Trout - White Hall, Md.</u> Address <u>R.R. 1</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Coronary occlusion</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/4/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Heston</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>7/4/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Richard J. Puelton</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 65 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice, Dulaney Valley RD				d. STREET ADDRESS 840 N. Chapelgate Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Marie J. Twanley				4. DATE OF DEATH Month Day Year July 30, 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Stolba				14. MOTHER'S MAIDEN NAME Josephine Lane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florence Cummings, 840 N. Chapelgate Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Phelibitis left leg DUE TO Fractured Hip (Right) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Imobiltization for Fractured hip caused Phelibitis INTERVAL BETWEEN ONSET AND DEATH Sudden 24 Hrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking down Hall Slipped & fell on hip					
20c. TIME OF INJURY Month, Day, Year 6/15/57 Hour 8 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/31/57	
EXAMINER'S NAME (Type) Charles F. O'Donnell				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 3/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Amundson Ave. Amundson				24a. REC'D BY REGISTRAR AUG 2 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07265

07277

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7mths24dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Baltimore		d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL	
d. STREET ADDRESS 313 Liberty Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herman Middle A. Last Ulbig, Sr.		4. DATE OF DEATH Month July Day 4 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1878
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofier		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Ulbig		14. MOTHER'S MAIDEN NAME Ella Hennon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 219- 01-7610	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac decompensation DUE TO 2 months (c) generalized severe arteriosclerosis DUE TO unknown		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.3		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 28 , 19 57 to July 4th , 19 57 , that I last saw the deceased alive on July 4th , 19 57 , and that death occurred at 5:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gertrude J. Fleischmann SPRING GROVE STATE HOSPITAL 7.4.57			
ACTUAL SIGNATURE Gertrude J. Fleischmann		PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 7th 1957		22b. DATE THEREOF July 7th 1957	
22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) (State) North Ave. East	
23. FUNERAL DIRECTOR'S SIGNATURE Leo S. Sisk		24a. REC'D BY REGISTRAR JUL 10 57	
24b. REGISTRAR'S SIGNATURE Rebecca			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

BUREAU V. S.

1957 OCT 11

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07279

CERTIFICATE OF DEATH

Reg. Dist. No.

07265

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN b 73 days		d. STREET ADDRESS 24 Dunkirk Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle A. Last VICARI		4. DATE OF DEATH Month July Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/03
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timekeeper	11. BIRTHPLACE (State or foreign country) Maryland
10b. KIND OF BUSINESS OR INDUSTRY Fruit Company		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Vicari		14. MOTHER'S MAIDEN NAME Mary Max	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-01-9066	
17. INFORMANT Clin. Rec. Div, Vets. Admin. Hospital, Ft. Howard, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 391X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION OF PART I (a) Chronic Bronchial Asthma. Chronic pulmonary emphysema. Arteriosclerotic cardiovascular disease. Pneumonia 241X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April 23 , 19 57 , to July 5 , 19 57 , and that death occurred at 4:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rolando P. Ponce de Leon Veterans Administration Hospital 7/6/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) ROLANDO P. PONCE de LEON Fort Howard, Md. 7/6/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-9-57	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery
22d. LOCATION (City, town, or county) (State) Texas, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc ADDRESS 6009 Harford Road		24a. REC'D BY REGISTRAR DATE 7/8/57
24b. REGISTRAR'S SIGNATURE Lewson L. Farber		

RUSSIA

1957 6 701

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07278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yr9mth9days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Gilbert Last Wadsworth				4. DATE OF DEATH Month July Day 31 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1879	
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Wadsworth				14. MOTHER'S MAIDEN NAME Mary Alice Wadsworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 57 , to July 31 , 19 57 , that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 10:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-31-57							
ACTUAL SIGNATURE Bruno Radauskas M.D.				PHYSICIAN'S NAME (Type) Bruno Radauskas Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/6/57		22b. DATE THEREOF 8/6/57		22c. NAME OF CEMETERY OR CREMATORY Union of Md. Anatomy Board		22d. LOCATION (City, town, or county) (State) Balto. 295, Greene St.	
23. FUNERAL DIRECTOR'S SIGNATURE Union of Md. (Anatomy) 295, Greene				24a. REC'D BY REGISTRAR DATE 8/6/57		24b. REGISTRAR'S SIGNATURE John P. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 9 50A

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle NMI Last Webb		4. DATE OF DEATH Month July Day 20 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1910
9. AGE (in years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 47 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Webb		14. MOTHER'S MAIDEN NAME Kate Loos	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none known	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] failure PART I. DEATH WAS CAUSED BY: Congestive heart failure IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic narrowing of left coronary DUE TO (c) Congenital cerebral spastic paraplegia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sudden death while eating meal; no signs of injury	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8/2/57	
22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Old Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fisher + sons		24a. REC'D BY REGISTRAR 1318 High	
24b. REGISTRAR'S SIGNATURE Aug 2 '57			

RECEIVED

AUG 2 1957

BUREAU V. 1

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 07281
 CERTIFICATE OF DEATH

07268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emilie Middle Vonide Hyde Last Weber				4. DATE OF DEATH Month July Day 8 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1873	
9. AGE (In years last birthday) yrs. 83?		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Unknown Von de Hyde				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, ganeralized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 25 , 19 57 , to July 8 , 19 57 , that I last saw the deceased alive on July 8 , 19 57 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslers M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 7-8-57				PHYSICIAN'S NAME (Type) Stella Wachslers, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/11/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
22d. LOCATION (City, town, or county) (State) Woodlawn, Md.				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Sons - Balt., Md.				24a. REC'D BY REGISTRAR 301-185			
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07269

07282

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gwyn Oak</u>		LENGTH OF STAY (in this place) <u>2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> <u>3601.4</u> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AUGSBURG Home</u>				STREET ADDRESS (If rural give location) <u>ROSELAWN AVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ADOLPH F WENDEL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 23 1957</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWER</u>		8. DATE OF BIRTH: <u>OCT 30, 1867</u>	
9. AGE last birthday: <u>90</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>ADAM WENDEL</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZ.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.:			
17. INFORMANT & ADDRESS: <u>6811 CAMPFIELD RD</u> <u>RECORDS AUGSBURG HOME</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0</u> <u>Broncho-Pneumonia</u>						<u>2 wks</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arterio-Sclerotic Heart Disease</u>						<u>4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>491X</u> (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arterio-Sclerosis</u>						<u>5 yrs</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14, 1955</u> , to <u>July 23, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>11:20^{PM}</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Paul L. Chamberlain</u>				ADDRESS <u>M.D. 4108 Shady Hts. Baltimore</u> DATE SIGNED <u>7/23/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>July 26, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/24/57</u>		REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Masten</u>		24. FUNERAL DIRECTOR <u>PAUL A. HEEMANN</u>		ADDRESS <u>6067 HARE RD.</u>	

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JUL 25 1957

BUREAU V. B.

07283

CERTIFICATE OF DEATH

07270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd</u>		d. STREET ADDRESS <u>2225 North Howard</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Williams</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Sept 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Hereford, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Doris Newmuis</u> Address <u>1920 Herbert St Baltimore 7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>over 3 yrs -</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>57</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 July</u> , 19 <u>57</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		ADDRESS (Street, city or town, state) <u>Cockeyville</u> DATE SIGNED <u>12 July 57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>	22d. LOCATION (City, town, or county) (State) <u>Hereford, Balto. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lohatman</u> ADDRESS <u>1701 Mc Culloch St Balto, Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lohatman</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. DATE OF DEATH [Faint handwritten date]</p>	
<p>11. PLACE OF DEATH [Faint handwritten place]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>14. OFFICIAL USE [Faint handwritten notes]</p>	

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JUL 19 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG218 7-23-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Essex, Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Essex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 Thompson, Blvd.	
3. NAME OF DECEASED (Type or print) Barbara M. Winkelman.		4. DATE OF DEATH Month July Day 14 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1865
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife at home		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harry C. Winkelman, Thompson Blvd. Essex.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anteriosclerotic Cardiovascular Disease DUE TO Carcinoma left Breast (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs 10 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1957 to July 14, 1957 , that I last saw the deceased alive on July 14, 1957 , and that death occurred at 5A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Baltimore Md	
PHYSICIAN'S NAME (Type) M. Baumgardner		DATE SIGNED 7/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/18/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Eastern Ave.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home		24a. REC'D BY REGISTRAR UII 16 1957	
24b. REGISTRAR'S SIGNATURE Edith Hurley			

JUL 16 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

07272

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Home		d. STREET ADDRESS 5123 Wetheredsville Road	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle L. Last Wright		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1882
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Ely Lilley		14. MOTHER'S MAIDEN NAME Eleanor Hyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward Lee Wright		Address 9 Wyndercrest Ave. (28)	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 min years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 447x			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 25, 1957 to July 2, 1957 , that I last saw the deceased alive on July 1, 1957 , and that death occurred at 7 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lorraine Fort		DATE SIGNED 7/3/57	
PHYSICIAN'S NAME (Type) Wetherdee FORT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-5-1957	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W. North Ave.	24a. REC'D BY REGISTRAR JUL 5 '57
		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		39		APRIL 14, 1924	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

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JUL 5 1957

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